The OIG Issues Supplemental Compliance Guidance for Hospitals
by Kenneth Yood

On January 31, 2005, the Office of Inspector General (OIG) issued its long-awaited Supplemental Compliance Program Guidance for Hospitals. This is the first time the OIG has updated its master list of compliance risk areas for hospitals since the first hospital compliance guidance was issued in February, 1998. As does the OIG’s annual Work Plan, the Supplemental Program Guidance provides a road map to possible areas of investigation and enforcement by the OIG this year and in the coming years. Therefore, hospitals should be mindful of these identified risk areas and review and update their corporate compliance programs accordingly. For those hospitals which have yet to develop a corporate compliance program, the Supplemental Guidance may be considered a wake-up call from the OIG admonishing hospitals and other providers to establish a corporate compliance program to, in part, limit their risks under the Medicare False Claims Act, the Federal Antikickback Statute, the Stark Law and other OIG enforcement tools.

Risk Areas

A. Submission of Accurate Claims and Information. According to the OIG, the single biggest risk area for hospitals is the preparation and submission of claims or requests for payment from Federal health care programs. All claims must be complete and accurate, and must reflect reasonable and necessary services ordered by a physician who is appropriately licensed and participates in the health care program from which the entity is seeking reimbursement.

The OIG lists some of the specific risks associated with claim preparation and submission: inaccurate coding; upcoding; unbundling of services; billing for medically unnecessary services or other services not covered by the relevant health care program; billing for services not provided; duplicate billing, insufficient documentation and false or fraudulent cost reports.

Finally, the OIG goes into significant detail regarding the risks associated with the following: outpatient procedure coding; admission and discharge policies; and supplemental payment considerations including abuse of the DRG outlier payments, improper claims for incorrectly designated provider-based entities, improper claims for clinical trials, improper claims for cardiac rehabilitation services.

B. The Referral Statutes.

1. The Stark Law. Given the recent publication of the final Stark II regulations, the OIG identifies enforcement of the Stark Law as a priority. The OIG also notes that the penalties for violating the Stark law are various: possible exclusion from the Medicare and Medicaid programs, civil monetary penalties and those penalties which relate to violations of the False Claims Act. The OIG advises that hospitals should implement systems to ensure that all conditions in the applicable Stark exception are fully satisfied when analyzing a physician/hospital financial relationship.

2. The Federal Antikickback Statute. The OIG identifies eight areas that are commonly known to give rise to Antikickback Statute violations: joint ventures; compensation arrangements with physicians; relationships with other health care entities; recruitment arrangements; discounts; medical staff credentialing; malpractice insurance subsidies and gainsharing arrangements. Accordingly these areas are going to be subject to heightened scrutiny.

C. Payments to Reduce or Limit Services. The Civil Monetary Penalty Law prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to
reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under the physician’s direct control. According to the OIG, gainsharing arrangements (arrangements in which a hospital gives physicians a percentage share of any reduction in the hospital’s costs for patient care attributable in part to the physician’s efforts) often implicate the Civil Monetary Penalty Law prohibition and are, therefore, subject to heightened scrutiny.

D. EMTALA. The OIG intends to focus on EMTALA compliance during the coming year and compliance should therefore be the focus of a compliance program.

E. Substandard Care. The OIG has authority to exclude any individual or entity from participation in Federal health care programs if the individual or entity provides unnecessary items or services or substandard items or services. The OIG intends to focus its audit priorities on the provision of substandard or unnecessary services.

F. Relationships with Federal Health Care Beneficiaries. The OIG is authorized to impose civil monetary penalties on hospitals that offer or transfer remuneration to a Medicare or Medicaid beneficiary that the hospitals knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider for which payment may be made under the Medicare or Medicaid program. Therefore, the OIG will closely scrutinize offers of gifts or gratuities to a beneficiary, any waivers of copayment amounts or deductibles, and the provision of free transportation.

G. HIPAA Privacy and Security Rules. The OIG intends to focus its audit efforts on compliance with the HIPAA Privacy Rule.

H. Billing Medicare or Medicaid Substantially in Excess of Actual Charges. The Social Security Act provides for the permissive exclusion from Federal health care programs of any provider that submits a claim based on costs or charges to the Medicare or Medicaid programs that is “substantially in excess” of its usual charge or cost. Therefore, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

Other Points of Interest

In addition to outlining risk areas for hospital internal audit review, the OIG has also used the Supplemental Program Guidance to offer some advisory guidance relating to common arrangements in the health care industry.

1. Hospital-Based Physicians. Hospitals often have arrangements with hospital-based physicians (pathologists, radiologists, etc.) in which the physicians do not receive direct compensation from the hospital. Instead, the physician compensation emanates from the physicians’ ability to bill third party payors (including Medicare and Medicaid) for professional services provided at the hospital. Notwithstanding this common arrangement, the OIG states that, “arrangements that require physicians to provide Medicare Part A supervision and management services for token or no payment in exchange for the ability to provide physician-billable Medicare Part B services at the hospital potentially violate the anti-kickback statute and should be closely scrutinized.” Indeed, the Supplemental Program Guidance lists “a hospital compensating physicians less than the fair market value for goods or services provided to the hospital by the physicians” as one possible form of “illegal kickbacks between hospitals and hospital-based physicians.”

2. Contractual Joint Ventures. The OIG has a “long-standing concern about joint venture arrangements between those in a position to refer or generate Federal health care program business and those providing items or services reimbursable by Federal health care programs.” As noted by the OIG, joint ventures can take a variety of forms including contractual arrangements between two or more parties to cooperate in “a common and distinct enterprise providing items and services thereby creating a ‘contractual joint venture.’” The OIG concludes that these contractual joint ventures are not likely to be subject to safe harbor protection. Therefore, each contractual joint venture must be examined on a case-by-case basis.

In analyzing these contractual joint ventures, the OIG has identified several factors for consideration including “whether the hospital is expanding into a new line of business created predominately or exclusively to serve the hospital’s existing patient base, whether a would-be competitor of the new line of business is providing all or most of the key services, and whether the hospital assumes little or no bona fide business risk.” An example of a potentially problematic contractual joint venture for the OIG would be a hospital contracting with an existing durable medical equipment (DME) supplier to operate the hospital’s newly formed DME subsidiary on a turnkey basis with the hospital providing referrals and assuming little or no business risk.

Finally, it is important to note that the OIG has concluded that common “under arrangements” agreements whereby an outside supplier provides services to hospital patients on the hospital’s behalf generally do not fall within the scope of problematic contractual arrangements. So long as certain precautions are taken (including fitting within a safe harbor), the OIG’s conclusion applies even when the outside supplier is owned, in whole or in part, by referring physicians.

3. Professional Courtesy. Professional courtesy arrangements often take the form of programs that offer free or discounted hospital services to medical staff, employees, community physicians, and their families and staff. In applying the Antikickback Statute, the OIG has concluded that the analysis “turns on whether the recipients of the professional courtesy are selected in a manner that takes into account, directly or indirectly, any recipients ability to refer to, or otherwise generate business for, the hospital. Therefore, although there are no applicable safe harbors for professional courtesy arrangements, such arrangements may survive scrutiny if they are provided on a blanket basis to all employees, medical staff members, etc.
If you have any questions regarding the OIG's Supplemental Compliance Guidance for Hospitals, or healthcare-related topics in general, please contact any of the following attorneys:

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