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OIG ratcheting up anti-kickback enforcement

OIG senior counsel says the agency is about to start picking up cases Justice passes up

The anti-kickback statute is alive and well, and health care providers should brace for increased enforcement activity in that area, warns **Vicki Robinson**, senior counsel at the Department of Health and Human Services' Office of Inspector General (OIG).

"You're going to see more enforcement in this area," Robinson said at the recent Healthcare Financial Management Association compliance conference in Washington, DC. "It's important to be aware of the anti-kickback statute and scrutinize your business arrangements."

Until now, the anti-kickback statute has mainly been enforced by the U.S. Department of Justice, Robinson notes. But that's about to change. "We [the OIG] have actually hired a former U.S. attorney whose primary focus is going to be bringing kickback cases," she says. "We intend to pursue cases that may not rise to the level of a case the Justice Department would prosecute criminally due to resource limitations or other factors, but still warrant prosecution."

According to Robinson, one new vehicle for enforcement will be the OIG's authority to impose civil monetary penalties (CMPs) for kickbacks, granted by the Health Insurance Portability and Accountability Act of 1996.

But it doesn't stop there. Robinson says the OIG is dramatically increasing the types of kickback arrangements it is investigating. Not long ago, she

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How to integrate physicians into your compliance plan

Integrating physicians into a compliance program is one of the greatest challenges facing hospitals, says **Paul Belton**, vice president for corporate compliance at Sharp Healthcare in San Diego. The reason is simple: Physicians still drive 75% to 80% of health care costs and control the documentation process.

According to Belton, there is a lot of confusion among physicians who have never been properly educated about many of the rules and regulations they confront on a daily basis. "There is a crying

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How to defend against false claims allegations

Consider this: From 1987 to 1998, 2,400 *qui tam* cases were filed in the United States. In 1987, 12% of all *qui tam* were health care-related. By 1998, that number had ballooned to 61%. The average recovery in 1998 was $8.6 million, and the take for each relator averaged $1.16 million.

Sandy Teplitzky, who heads the health law department at Ober Kaler in Baltimore, says those facts alone should eliminate any doubt that the False Claims Act is driving government's anti-fraud efforts in the area of health care. "Attorneys in the plaintiffs' bar are actively soliciting these cases," Teplitzky asserts. In some cases, he says, *qui tam* relators are even fighting with each other over who uncovered the most valuable evidence.

Because the False Claims Act is an intent-based statute, the three most important things are "documentation, documentation, and documentation," Teplitzky contends. He says even "self-serving documentation" is acceptable as long as it is accurate

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OIG enforcement

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says, anti-kickback cases were relatively straightforward and easy to spot, a simple *quid pro quo* of patient referrals in exchange for money. But while this type of garden-variety kickback is still relatively common, more sophisticated ways of disguising payments for referrals in complex business transactions have surfaced as the business of medicine has become more complex. "This trend is requiring us to get more sophisticated in how we look at health care business transactions," says Robinson.

"We see floors of hospitals reconstituted as separate hospitals with physician investors," she reports. "In some cases, these arrangements are potentially designed to circumvent the Stark 'whole-hospital' exception."

Robinson says the OIG is also scrutinizing clinical joint ventures, where hospitals close existing services and reopen them, sometimes right next door as joint ventures with physicians, thereby cutting physicians in on the profits from the services.

According to Robinson, other examples of potential kickback violations include a range of consulting, management, and research grants, as well as space and equipment rental arrangements that providers use to create "a paper cover for unlawful payments for referrals." Often, the agreed-upon services are not rendered, or the payments exceed fair-market value for whatever services are rendered, she maintains.

"The bottom line is that, whether you call it an investment interest, a consulting fee, a research fee, or a rental payment, if it is a payment for referrals, it is a kickback," she argues. "You can't paper it over with 20 different complicated business structures or contractual arrangements."

Gabe Imperato, a health care attorney who specializes in that area, says the trend Robinson is warning about is already in evidence. "There has been aggressive enforcement under the kickback statute both in terms of volume and sophistication," reports Imperato, of Broad & Cassel in Fort Lauderdale, FL. However, criminal enforcement by U.S. attorneys in some of those kickback cases would have been more appropriately handled as a CMP or exclusion case by the OIG, he argues.

Imperato says the problem is that a case does not get to the OIG for administrative action unless the local U.S. attorney can't or won't prosecute it criminally. "They have to decline before the OIG gets into the picture," says Imperato, who argues there should be some mechanism for a decision to be made up front about whether it is a criminal or a civil kickback matter.

Imperato says most OIG attorneys have considerable experience in that area, and "a basic appreciation for the kickback statute and its application." But newer FBI agents and U.S. attorneys who lack the same experience are sometimes too eager to bring cases. In fact, some cases involve dollar amounts and numbers of physicians that would suggest half the physician population in an area is involved in kickback arrangements, he adds. ■

False claims charges

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and contemporaneous rather than after the fact. Teplitzky says there are seven key questions that compliance officers and others should consider to help insulate their facilities from the threat of government actions.

1. ***What is the effect of your relationship or your business transaction on costs to the federal health care program?*** Teplitzky says this is still the first question that should always be asked. "Just because something is more expensive does not mean it is illegal," he argues. Nevertheless, if what you are doing has the effect of increasing costs to the federal health care program, it will be closely scrutinized, warns Teplitzky.

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2. ***What is the effect on utilization of health care services?*** Under fee-for-service payment, the government was mainly concerned with overutilization, while under managed care the concern shifted to underutilization. Teplitzky says providers should focus on "accurate utilization," and how to document services effectively.

3. ***What is the effect on quality of care?*** Most people don't realize that quality assurance programs are an integral part of compliance and part of the defense against fraud and abuse allegations, Teplitzky says. The key is to demonstrate not only that everybody who needed services received them, but also that the services they received met professionally recognized standards of care.

4. ***What is the effect on access to care?*** "If you are making a service available to people who could not afford it or could not get it in the past, that's a good thing," he says. "If what you are doing is prohibiting access to care, the government is going to view that as potentially bad."

5. ***What is the effect on patients' freedom of choice?*** "You won't find this anywhere in the law but it is one of the first questions that the government asks in an investigation," Teplitzky warns. The litmus test is whether you have limited the ability of the patient to make the decision on what services or products to get, and from whom or from where to get those services, he explains.

6. ***What is the effect on competition?*** "You won't find this anywhere in the legislative history of the statutes, either," Teplitzky asserts. But he points out the OIG considers it one of the four main areas the statute is intended to protect against. "What matters is that we now know the government is going to look at the effect on competition," Teplitzky asserts. "If your intent is to improve competition, that is a good thing," he explains. "If your intent is to drive all of your competitors out of business, I will put you in touch with one of my partners who practices antitrust law."

7. ***What is the effect on professional judgement?*** "Every day of our lives, there are economic issues that influence the decisions of physicians," Teplitzky argues. "The question is whether those issues are influencing physicians inappropriately and whether they are leading physicians to do things that they ought not do." ■

Integrating physicians

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need from physicians looking for this education, specifically in billing and coding," he asserts. "We have not provided that as an industry, and we have not provided that through our compliance programs."

Belton underlines the cost of that confusion by pointing to estimates made by the Health and Human Services' Office of Inspector General earlier this year that the cost of physician documentation errors topped $3 billion. Roughly half that amount ($1.51 million) was due to incorrect coding, while another $656 million was due to insufficient documentation, and $432 million was attributed to no documentation.

By contrast, only $291 million was attributed to noncovered services, and $112 million to lack of medical necessity. Belton says one tactic to combat that lack of awareness among physicians is to focus on the risk and personal liability physicians confront on a local basis. "Look at those areas where local physicians are either running afoul of the law or have a situation where there is some type of non-compliant activity," he advises. "That will hit home a little bit harder."

When it comes to integrating physicians, Belton argues that hospitals should seek to capitalize on familiarity by starting with the existing structure within the hospital. That means looking at how the medical staff structure is set up organizationally and strategically evaluating where physicians are involved in the process. By contrast, he says, the biggest mistake hospitals can make is to create a new compliance department and allow it to function as a separate silo department that is not integrated with existing departments.

While most physicians are not yet familiar with compliance, they are familiar with risk management, quality assurance, medical chart review, and accreditation standards, notes Belton. For example, he points out that physicians have always been concerned with quality of care, an area that the False Claims Act is now flirting with. "What you want to do is dovetail with existing committees and subcommittees that are hospital-based."

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Belton says that utilizing the existing medical staff structure also means making presentations to the medical ethics committee and recruiting the head of the medical staff as a member of the compliance committee. The next step is to establish regular physician presentations that reinforce a consistent message, he says.

However, Belton says those presentations are more effective as concise 20-minute sessions rather than marathon sessions that combine specialists. "Be careful about having an internal medicine specialist sitting next to a cardiologist or trying to mix your specialties because it won't work," he asserts. "A cardiologist will want to hear from a cardiologist."

Sometimes external physician consultants can assist in that area. However, Belton warns that external specialists are often difficult to identify, and using consultants that lack genuine expertise can actually rob a compliance program of its credibility. "I have very great difficulty finding a radiologist that can come in and talk to radiologists about interventional coding," he reports.

Belton adds that hospitals should utilize the most recent profiling data that identify coding patterns. He says hospitals must capitalize on information that shows physicians how data are being collected and why they are at risk. Sometimes, that can even include examples of auditing tools used by the local carriers, he adds. ■

Congress likely to renew advisory opinion program

Health care providers wondering what Congress may have in store for them in the waning days of the 105th Congress have little to fear. In all likelihood, legislators will renew the advisory opinion statute and possibly expand the rights providers have to review decision by the Health Care Financing Administration.

Also possible, but less likely, is legislation that would rein in the Stark II self-referral laws, according to several senior congressional staffers. Most of those questions will be answered later this week when the House Ways and Means Committee is expected to pass a Balanced Budget Refinement Act (BBRA).

All sides agree the most likely item is a reauthorization of the advisory opinion process, which expired last month. Providers also can expect to see certain Freedom of Information Act (FOIA) protections not included in the current statute added to the process. Those protections would be designed to protect providers from FOIA requests made by trial lawyers who later use the information disclosed in *qui tam* filings against them.

The self-referral bill introduced last year by House Ways and Means Health Subcommittee Chairman **Bill Thomas** (R-CA) may also surface, says a Ways & Means staffer. "The thought was to include it in BBRA, but that may poison the soup," he explains.

Meanwhile, House Committee on Commerce Chairman Tom Bliley (R-VA) last week introduced legislation that would make information included in the National Practitioner Data Bank (NPDB) available to the general public. The NPDB, which contains disciplinary and medical malpractice payment information of physicians and other health care providers, is currently available only to state licensing boards, hospitals, and certain HMOs.

Currently, the Patient Protection Act, would give the public access to disciplinary information about adverse actions taken against physicians and hospitals, as well as medical malpractice payment information and the ability to compare physicians within a particular specialty or a given state.

Bliley argues this would strike a balance between the rights of patients and physicians.

The Chicago-based American Medical Association (AMA) says otherwise. "We look at this as retribution for our work on the Patient's Bill of Rights," says **Thomas Reardon**, the AMA's immediate past president. 0The AMA supports the original concept of the data bank as a repository for disciplinary actions regarding physicians including those who have lost their license. But he says the AMA opposes the inclusion of malpractice settlements. "The fact that a physician is sued has nothing to do with competency."

Instead, Reardon says the AMA supports what is unfolding at the state level, where state medical societies are working with state medical boards to develop Web sites that include disciplinary action but not malpractice information. In fact, 28 states already have such Web sites. ■