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COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTH CARE COMPLIANCE OFFICERS

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Compliance chiefs: Flexibility, operations keys to success

As health care compliance efforts mature, compliance officers take stock

In a few short years, the health care industry has gone from concept to development in its compliance efforts, and now it's moving to managing program effectiveness. **Vickie McCormick**, integrity officer at UnitedHealth Group in Minneapolis, says that while people keep looking for the "magic bullet" for structuring a compliance program, one of the lessons of the past few years is that no single model will work for all organizations.

"You really need to look within your organization and understand its dynamics, culture, and personality as well as its size, structure, and geography," McCormick says. For example, because UnitedHealth has a number of separate operating units, it also has a number of different models. "What works well within an HMO may not work within an employee assistance program," she explains.

McCormick says another important lesson deals with "operationalization." That means compliance officers must make sure that compliance activities are part of the operational staff responsibility. She says that, too often, compliance is "siloed" and tasked with making sure the rest of the organization is in compliance with all laws and requirements.

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OIG report shows continued emphasis on false claims

The Health and Human Services' (HHS) Office of Inspector General's (OIG) Semi-Annual Report, released this month, shows a remarkably steady effort to root out fraud and abuse that continue to be spearheaded by the False Claims Act. "Almost all of our action these days involves False Claims Act cases brought by relators and then worked on by the government," reports **J.D. Epstein**, a partner with Vinson Elkins in Houston. "That is the front line right now."

Epstein says it is still difficult to assess where the government is in terms of False Claims Act cases relating to the Stark self-referral laws. "We

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How and when to report overpayments

Given the complexity of Medicare regulations and the sheer number of claims providers submit, overpayments are virtually inevitable, warns **Steve Ortquist**, director of corporate compliance at Rush-Presbyterian St. Luke's Medical Center in Chicago. "From time to time, errors are going to occur that we have to deal with," he says. The question is what to do about those overpayments.

Risk assessments, auditing, and monitoring aimed at uncovering errors alone are not the answer, Ortquist warns. If those systems are working effectively and overpayments are uncovered, providers then must determine whether they can make a routine return of the overpayment or make a voluntary disclosure.

"People think that simply because they are holding an overpayment, they have to go to Office of Inspector General [OIG] or Department of

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Compliance chiefs

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"That isn't going to happen," she argues. "Every person within the organization must understand that he or she is responsible for making sure that their area is compliant." If you "silo" compliance in a single department, you are going to have endless problems in the rest of the organization, she warns.

McCormick says another lesson is that compliance officers should use the systems they have in place and get to know people in the functional departments, such as human resources, public relations, and accounts payable. For example, she says communications has helped make the information sent out to employees more "user-friendly" and less legalistic.

McComick says public relations also helped her develop a consistent "look and message" that helps to promote a brand identity for the compliance program. "Compliance officers are marketing the compliance program to employees, so when they see something, they identify it with the compliance program," she explains.

Similarly, she says that when UnitedHealth recently moved to an on-line exit interview process, she worked with the human resources department to develop a process to include three questions focusing on integrity and compliance. "If anybody answers those questions positively, I receive an e-mail notification and can see what those responses are," she reports.

In addition, McCormick says she works with accounts payable to identify business associates for Health Insurance Portability and Accountability Act compliance. "They are the ones who send out the checks, and they know a large percentage of who it is that would constitute a business associate," she explains.

McCormick says she also works with accounts payable as a backup on background checks for the OIG when checking for outside vendors. "As a safety net, we have accounts payable do a check of all new vendors before they are entered into our system and then an annual check of all vendors," she explains.

Often, the simple lessons are the most difficult to grasp and remember, says **Anthony Boswell**, corporate compliance officer at Dallas-based Laidlaw Inc. "Never underestimate the need for a training session," he says. Since most information is forgotten within a month, compliance officers must constantly be out in front of the employee base sharing new information and reinforcing existing best practices.

Boswell notes that a strong private sector ad campaign usually lasts only six months. Compliance officers must think along the same lines and refresh their message continually, he says.

In addition, old habits die hard. That means compliance officers must encourage employees who are eager to adopt best practices and use auditing and monitoring programs. "Training an employee base is similar to raising children," he says. "You can't be there all the time."

Also important is to learn and speak the language of business, Boswell says. "We are being asked in new and creative ways to demonstrate the value that we as compliance departments bring to organizations," he reports. "If we can't do that in dollars and cents, I fear that we will lose some of our 'effectiveness' in the minds of business people," he asserts.

Already, he says, there is a large "push-back" based on budgeting, and part of that results from a lack of understanding about the value of compliance. The formula for demonstrating that value will vary from organization to organization, but accomplishing it in some fashion is critical, he says.

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John Markus, senior vice president of Fresenius Medical Care North America in Lexington, MA, says the major challenge for compliance officers over time is to stay focused and avoid complacency. He points out that a seven-figure settlement in the 1980s was noteworthy. Today, settlements can reach several hundred million dollars. "Sometime within the next few years, somebody is going to pay a billion dollars," he predicts.

Markus says the government is methodically expanding its reach throughout the health care industry, from labs and hospitals to skilled nursing facilities and home health. "There are countless FBI agents and countless OIG agents who have nothing better to do than open investigations," he says. A final lesson of the last few years is that providers can count on that to continue, he says. ■

Reporting overpayments

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Justice [DOJ], when in fact it may be entirely appropriate to make those refunds directly to the intermediary or carrier," Ortquist argues.

Ryan Meade, a health care attorney with Katten Muchin in Chicago, says the legal obligation can be boiled down to a simple principle, which is that a provider must return money that is not owed to it. "But most 'first-blush' simple legal principles tend to be anything but simple when you really start looking at them," he warns.

Meade points out that the term "overpayment" by itself doesn't mean much, because overpayments can result from anything from simple technical errors to intentional fraud. "In some respects, the obligation to return the money does not have much to do with how you got the money," he says. However, a provider's response may carry its own administrative, civil, or criminal liability. In short, providers can turn civil liabilities into criminal penalties by not returning the money, he explains.

Ortquist notes that the OIG's Provider Self-Disclosure Protocol covers situations that potentially violate criminal, civil, or administrative law and distinguishes those from situations involving overpayments and errors, which can simply be returned to fiscal intermediaries (FIs) and carriers. But he says that document primarily deals with non-routine matters. Unfortunately, there is little guidance beyond that, he adds.

Worse yet, Ortquist says that a recent review of five large FI web sites turned up no specific guidance on how to handle overpayments. "That sets up a situation where providers are forced to engage counsel," he says.

Ortquist says providers should be aware of HCFA's "Procedures for the Benefit Integrity and Medical Review Units on Unsolicited/Voluntary Refund Checks," which instructs FIs not to return repayments to providers and outlines the procedures FIs must follow.

Another relevant guidance is the Health Care Financing Administration's (HCFA's) Overpayment Refund Form. But Ortquist cautions that there is considerable discussion among outside counsel on whether providers should use this form in making repayments.

Nevertheless, providers contemplating the return of an overpayment should look at these documents, he argues. "I can tell you from experience that when an intermediary receives an overpayment return, they do look to this guidance, and they expect providers to be able to provide the information discussed in these program memorandum," he says.

Meade warns that providers must be aware that, in addition to general criminal laws that obligate them to return government funds not owed to them, there are specific health care laws that address this issue. "There are no easy guidelines for determining when to return overpayments directly to intermediaries and carriers as opposed to making a voluntary self-disclosure to the OIG or DOJ," he says.

While general laws do not explicitly refer to an obligation to return overpayments, the statute does prohibit providers from concealing or failing to disclose the fact that they submitted claims for reimbursement they were not owed, or otherwise "converting" those funds to private use.

Providers often forget they also have an obligation to return money to commercial plans, adds Meade. The "Theft or Embezzlement in Connection with Health Care" statute effectively expands the concept from government-funded health care programs to all health care benefit plans, he explains.

Finally, providers should not forget about state

fraud laws along with a growing number that have their own *qui tam* provisions on the books. Meade says that most states have adopted laws criminalizing health insurance fraud and have criminal conversion laws consistent with the federal conversion prohibition.

In general, Meade says it is best for providers to return directly to intermediaries and carriers any overpayments that can be identified as small and isolated and do not appear to be the result of errors carrying false claims liability. "But such an identification is rarely simple," he cautions. ■

When should you return overpayments directly?

Ryan Meade, a health care attorney with Katten Muchin in Chicago, says the following considerations weigh in favor of direct returns:

- Did the error occur for a very short period of time?
- Is the error isolated to specific claims identified in the compliance review?
- Does the error appear to be random, with no identifiable pattern and confined to the specific claims identified in the compliance review?
- Is the amount of return small compared to the provider's overall revenue from the health program receiving the refund?
- Is the amount of overpayment needing to be returned similar in size to the provider's other recent refunds?
- Does the provider have a good working relationship with the intermediary or carrier who will receive the refund?
- If the overpayment is sizable, is this refund the first significant refund? If the provider has been the subject of recent *qui tam* suits, government investigations, or has made sizable self-disclosures recently, then it may be more appropriate to self-disclose to the OIG or DOJ, Meade cautions.
- Is the provider satisfied that there is no known *qui tam* relator?

Ortquist says it's possible to build effective working relationships with people at the FIs who are responsible for processing overpayments. "I encourage anybody in a compliance role to make efforts to find out where those people are and work on building those relationships," he says. ■

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have seen none," he reports. "We still don't have the final Stark II regulations, and I think the government is a bit uneasy about bringing cases under Stark without final regulations."

Kickbacks are another story, Epstein says. The OIG highlights this area in its most recent report, citing several major settlements involving physicians and durable medical equipment companies.

Marc Raspanti of Miller Alfonso in Philadelphia, predicts this trend will continue as the number of physicians who are willing to blow the whistle on hospitals, competitors, and HMOs continues to increase. Once-common interactions with pharmaceutical companies and ancillary service providers, such as educational grants, lavish dinners, and payments for new drug trial runs, now are perceived as criminal. "These areas will be looked at by the government as potential inducements for referrals," he says.

The OIG reports $10 billion in savings for the first half of fiscal year 2001. Most of that — $9.5 billion — was attributed to implemented recommendations and other actions to put funds to better use. Another $335 million was realized in audit disallowances, and the remaining $249 million came from investigative receivables.

The OIG also reports 1,610 exclusions of individuals and entities for fraud and abuse of federal health care programs, 213 convictions of individuals or entities that engaged in crimes against departmental programs, and 209 civil actions.

The OIG reports that it is still investigating more than 100 hospitals under its pneumonia upcoding initiative. To date, 23 hospitals have settled their liability for upcoding by paying more than $23.7 million. Settlements stemming from the Physicians at Teaching Hospitals initiative now stand at almost $99 million, while 2,799 hospitals have now settled with the government for over $73 million for investigations related to the Three-Day Window project.

The OIG also reports that, between Oct. 1, 2000 and March 31, 2001, it collected $325,000 in settlement amounts from 15 hospitals and physicians for violations related to the patient anti-dumping statute. ■