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Congress, OIG focus on fraudulent health care consultants

GAO goes undercover to find consultants who encourage clients to bilk Medicare

Sen. **Charles Grassley** (R-IA) may no longer wield the gavel of the Senate Special Committee on Aging. But health care providers can rest assured that the man responsible for reinvigorating the False Claims Act and launching numerous government initiatives against health care fraud still is committed to rooting out fraud and abuse. Grassley's latest target: health care consultants.

A few months ago, Grassley gave the General Accounting Office's (GAO) Office of Special Investigations (OSI) reports that some health care consultants were teaching providers how to defraud federal health programs. "What [the GAO] found is astonishing and disturbing," Grassley told the Senate Finance Committee at a special hearing on the subject last week. "Consultants were teaching providers how to upcode and circumvent compliance regulations."

According to Grassley, there is no way of knowing how many consultants are providing bad advice because there is no mandatory accreditation or certification for health care consultants. "Anybody can put out a shingle and call themselves health care consultants," he maintains.

Last week, OSI managing director **Robert**

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OIG says self-disclosure by providers is working

Most of the 127 self-disclosures reported to the government since 1995 have been sent to carriers for refunds, according to **Michael Shaw**, an attorney with the Health and Human Services' (HHS) Office of Inspector General (OIG). However, there have been False Claims Act and civil monetary penalty settlements associated with those self-disclosures, adding up to $41.8 million and 65 pending cases, he reports.

"These are complex matters that needed to be adequately reviewed, and there was the potential for liability in most of those cases," contends Shaw. Nevertheless, in most cases,

*See **Self-disclosure**, page 4*

GAO report gives mixed messages on EMTALA

In a General Accounting Office (GAO) report released June 22, many hospitals and physicians contend that more patients visit the emergency room for nonurgent services, resulting in overcrowding and delays because of EMTALA.

But GAO says the jury still is out on the overall impact of EMTALA because there are no data on the incidence of patient dumping prior to its enactment. Moreover, the only measure of current incidence — the number of confirmed violations — is imprecise, the agency adds.

Some providers also argue that fewer physicians are joining hospital staffs and participating in emergency department on-call panels because EMTALA forces them to provide uncompensated care. But again, GAO says that other factors such as the ability to perform procedures in nonhospital settings may have reduced those incentives for certain specialists to serve on hospital staffs.

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Health care consultants

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Hast told the Finance Committee that GAO went undercover and discovered health care consultants who instructed providers not to report or refund overpayments received from insurance companies.

He says consultants also encouraged the performance of medically unnecessary tests and procedures to generate documentation supporting a higher level of complexity than providers actually confronted during the patient's treatment.

Hast says one consultant suggested that providers discourage patients with low-paying insurance plans, such as Medicaid, from using their services by limiting services provided to them and scheduling appointments for such patients at inconvenient times of the day.

According to Grassley, the Health and Human Services' Office of Inspector General (OIG) also has been zeroing in on consultants and has discovered large providers being instructed on how to unbundle payments and upcode on large-volume common illnesses such as pneumonia.

Lew Morris, assistant Inspector General for legal affairs at OIG, cited the following examples for the committee:

♦ Two consultants improperly advised more than 100 hospitals to unbundle clinical laboratory tests into their component parts and bill higher rates for the individual components. The consultants assessed the hospital's coding and billing procedures and advised them on reimbursement maximization techniques. Some hospitals submitted false claims for unnecessary tests and services as a result.

The two consultants facing civil charges were excluded from the Medicare and Medicaid programs for three years and agreed to cooperate in the government's effort to investigate the hospitals that benefited improperly from the fraudulent billing scheme. The investigations so far have resulted in civil actions against 36 hospitals and the payment of fines and penalties in excess of $11 million.

♦ A billing consultant who contracted with physicians to code, bill, and collect for emergency department services was found liable under the False Claims Act and agreed to pay $15.5 million to resolve his civil and administrative monetary liabilities. Employees had been routinely billing Medicare and Medicaid for higher levels of treatment than were provided or supported by medical record documentation. So far, the consultant's clients have paid $5.8 million to resolve civil liabilities stemming from this fraud scheme.

♦ A hospital contracted with a coding consultant who claimed he could help maximize Medicare revenues by optimizing the coding of claims associated with pneumonia patients. That hospital agreed to settle allegations that it improperly upcoded Medicare claims, and an additional 26 hospitals also have settled their civil and administrative liabilities for a total of $26.8 million.

Worse yet, Morris says other consultants learned of the pneumonia upcoding scheme and encouraged their hospital clients to falsify Medicare claims for the treatment of pneumonia. The OIG says that as the word spread among consultants, the scheme expanded throughout the hospital industry. The OIG simultaneously released a Special Advisory Bulletin on the practices of business consultants. **(See related story, page 3.)**

See the next issue of *Compliance Hotline* for advice on working with consultants, including how to establish effective reporting relationships and accountability. ■

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Editor: **Matthew Hay** (703) 721-1653 (MHay6@aol.com)
Managing Editor: **Russ Underwood** (404) 262-5521 (russ.underwood@ahcpub.com)
Coles McKagen (404) 262-5420 (coles.mckagen@ahcpub.com)

Vice President/Group Publisher: **Brenda L. Mooney** (404) 262-5403 (brenda.mooney@ahcpub.com)
Editorial Group Head:
Copy Editor: **Nancy McCreary**

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OIG offers guidance for dealing with consultants

The Health and Human Services' (HHS) Office of Inspector General (OIG) last week released a Special Advisory Bulletin on dealing with health care consultants that says the first thing providers should do to protect themselves when engaging consultants is to be alert for illegal or misleading representations.

For example, consultants may falsely claim they have "inside or special access" to the OIG or claim that their services or products are approved, certified, or recommended by Medicare or HHS.

The OIG warns providers to be alert for:

- Valuation consultants who promise that their appraisal of a physician's practice will yield a fair-market value that satisfies a client's demand for a particular valuation, regardless of the actual value.
- Billing consultants who claim their advice will result in a specific dollar or percentage increase in Medicare reimbursements, regardless of the prospective client's particular circumstances. (The consultant's fee often is based on a percentage of the increased reimbursement.)
- Consultants who promise to increase Medicare revenues for laboratory services by showing their clients how to disguise double billings and claims for medically unnecessary services.
- Reimbursement specialists who suggest that a client use inappropriate billing codes to elevate reimbursement and describe methods to avoid detection.
- Consultants who advise a client to modify or customize a routine medical supply in an insignificant manner solely to justify billing the item at a higher rate.
- Reimbursement specialists who suggest that a client bill for an expensive item with a high reimbursement rate when a less expensive item with a lower reimbursement rate actually was provided to the patient.

For a full copy of the advisory bulletin, go to www.os.dhhs.gov/progorg/oig/new.html. ■

EMTALA report

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Some hospitals and physicians expressed significant confusion regarding the scope of EMTALA, GAO reports. In fact, more than 40% of emergency physicians and more than 60% of emergency department directors recently told the Department of Health and Human Services' Office of Inspector General that parts of EMTALA are unclear.

Hospitals and physicians have told GAO they have questions about how a medical screening exam differs from initial triage or a general exam, how EMTALA applies to certain on-campus and off-campus hospital departments, and how much follow-up care they are obligated to provide to emergency department patients.

The total number of EMTALA violations and fines still is small. On average, since 1995, the Centers for Medicare and Medicaid Services (CMS-formerly the Health Financing Adminstration) regional offices have directed state survey agencies to investigate about 400 hospitals yearly and have cited about half of them for EMTALA violations.

From 1995 through 2000, the OIG imposed fines totaling more than $5.6 million on 194 hospitals and 19 physicians, reports GAO. The majority of fines were $25,000 or less.

EMTALA experts say those numbers don't tell the full story, however. Health care attorney **Lowell Brown**, of Foley & Lardner in Los Angeles, says the biggest problem with EMTALA is not that it is responsible for emergency room overcrowding or even the fines that are associated with it. The biggest problem is that doctors, nurses, and other hospital staff are very preoccupied by EMTALA, and providers that face an EMTALA violation are forced to divert significant resources from other areas.

"EMTALA is like a virus that has infected almost every part of the hospital," he asserts. "That is very hard to measure."

As for the GAO report itself, Brown says there is good and bad news. The good news is that providers have a document that reflects some of the major concerns providers have about EMTALA from an official government agency. The bad news

(Continued)

is that the report itself is ambivalent.

Health care attorney **Steve Lipton**, a partner with Davis Wright in San Francisco, agrees that many aspects of the GAO report are disappointing. For one thing, it does not address whether EMTALA has exceeded legislative intent, he says. "It does address the concerns of providers about the expansion of EMTALA to off-campus," he explains. "But it does not look at all at expansion of EMTALA to the inpatient side."

Brown also raised concern about GAO's recommendation to establish an advisory group of EMTALA stakeholders to provide guidance to surveyors in applying the law. "The government has a tendency to expand the law beyond its original intent every time they interpret it," he argues. "When there is an ambiguity, they always err on the side of broadening the obligations of providers."

Another area that continues to vex providers is the final Stark II regulations, which also were swept up in the administrative freeze imposed by the incoming Bush administration. In the case of the Stark II self-referral regulations, a final rule has already been published. However, CMS officials have been prohibited from answering the inevitable questions that have surfaced about the complex regulations.

To see the entire GO report, go to ww.gao.gov. ■

Self-disclosure

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the final resolution is a referral to the contractor for a refund, he said during the Philadelphia-based Health Care Compliance Association's (HCCA) June 27 audio conference on self-disclosure.

Shaw says it often is a difficult task to determine whether a sanction is warranted. One of the benefits of the self-disclosure protocol is an expedited review from the government on probable violations rather than a lengthy investigation that may ensue if the matter instead is discovered by the government. However, one of the problems is that providers often submit a request for consideration and then take a long time to give the OIG all the information it needs to appropriately examine the disclosure.

The Department of Justice (DOJ) has no formal program with respect to the False Claims Act or health care, notes DOJ attorney **Lawrence Freedman**. But he notes that the act does have a little-known provision for self-disclosure. For providers who qualify under these provisions, the statute reduces damages from treble damages to double damages.

To qualify, the provider that committed the violation must furnish officials with information about the violation within 30 days after which the information was first obtained, says Freedman. "The 30 days is a serious date," he warns. "What you know is what you know."

The safest place to make the self-disclosure is often the OIG, according to Freedman. But providers also are free to approach U.S. Attorney's Offices, DOJ, or other investigative agencies on a more informal basis, he adds. Providers should carefully consider who to report to, but reporting to several agencies can rarely hurt, he says.

Once you discover a serious problem, or a problem that you think may have False Claims liability, it is very important to begin an internal investigation right away, says **Ryan Meade**, a health care attorney with Katten Muchin in Chicago. "It is important to get on top of the facts and demonstrate that you respond quickly to compliance problems," he says.

If there is potential False Claims liability, that investigation should be conducted under attorney/client privilege, and counsel should be engaged to undertake the internal investigation, he adds. That will make all findings privileged and not discoverable.

While speed is important, thoroughness is just as important, Meade adds. If you are going to reduce your risk of *qui tams* being filed, it is important that you disclose all relevant facts to the government. "Sometimes, that may mean interviewing people twice," he says.

Finally, Meade says that while cooperating with the government is important, providers making a self-disclosure should ask the agency they approach to notify and coordinate with other agencies. While it is not necessary that numerous agencies be involved to reduce your *qui tam* risk, Meade says that often helps to present a better "fact scenario" when several agencies are aware of the problem. ■