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OIG targets Medicare oversight of ambulatory surgery

Report raises concerns about possible 'alternative agenda,' attorney says

The Centers for Medicare & Medicaid Services' (CMS) oversight of ambulatory surgical centers (ASC) has not kept pace with the explosive growth of these facilities, which more than doubled in number between 1990 and 2000, according to the Health and Human Services' Office of Inspector General (OIG). "Oversight of ASCs is more important then ever," the OIG asserts in a final report issued Feb. 26. "Medicare's system of quality oversight falls short."

While no one questions the need for adequate oversight, the OIG's missive troubles some observers. "It is hard to argue with the need for quality care," says **Robert Homchick**, a partner with Davis Wright in Seattle. "What I am concerned about reading in this report is that the resulting conditions of participation and other steps suggested by the OIG could result in new regulatory hoops that are meaningful only to CMS rather than the quality of the care provided."

In fact, the OIG itself says the question of quality of care was beyond the scope of the report. "We did not attempt to answer that question in this report," says OIG spokesman **Ben St. John**. But he adds that the study did find some anecdotal information that it considers troubling. Although ambulatory surgery has been shown to have

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Don't let HIPAA myths derail compliance efforts

Preliminary results from the Chicago-based Healthcare Financial Management Association's (HFMA) membership survey on HIPAA readiness indicate that an alarming number of entities have done little to implement some of the Health Information Portability and Accountability Act (HIPAA) compliance requirements. Worse yet, new myths and misunderstandings constantly are cropping up.

The best way to sort through the HIPAA facts versus the fiction is to review the rules, assert **Gail Sausser**, a health care attorney with the Washington, DC-based Vinson and Elkins and **Tom**

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When to perform an internal investigation

There are risks to conducting internal investigations, warns former federal prosecutor Robert Litt of the Washington, DC, law firm Arnold & Porter. But he says the benefits often outweigh those risks.

"An investigation might spark the government to look into something they did not even know about," he warns. Likewise, he says it is very difficult to conduct an internal investigation without any word of it leaking out. Also, providers might discover that what they thought was a very small problem is a much larger problem.

Those caveats aside, Litt says providers are well served to launch an investigation when they smell trouble. "My view is always that you are better off knowing than not knowing," he asserts. "If there is a problem out there, the likelihood is that sooner or later it is going to come to light."

According to Litt, investigations can be triggered

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Ambulatory surgery

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good outcomes, routine procedures can result in serious complications and death, St. John says.

Between 1990 and 2000, the OIG reports, the annual volume of major procedures ASCs performed increased by 730%, from 12,000 to more than 101,000 procedures.

But according to the OIG, CMS oversight of these services has not kept pace. Nearly a third of ASCs certified by state agencies have not been recertified in five or more years, and the conditions of participation, which drive the state agency certification process, have not been updated since 1982.

ASCs are surveyed at least every three years, notes the OIG. But it points out that this survey process devotes less attention to verifying compliance. CMS also found that CMS does little to hold state agencies and accreditors accountable to Medicare and the public.

Based on these findings, the OIG recommends that CMS determine an appropriate minimum survey cycle by state agencies, update the Medicare conditions of coverage of ASCs, and hold state agencies and accreditors more fully accountable to the public and the Medicare program.

Homchick says he worries about "an alternative agenda" that might lie behind these recommendations. "ASCs are lower-cost entities for the delivery of care, and I would hate to see them encumbered by regulations that are not tailored to maximize their efficiency," he asserts.

While the OIG says CMS responded "positively" to its report, it also notes that CMS did not fully commit itself to a number of the recommendations, particularly those calling for a minimum survey cycle and a more accessible complaint process.

According to the OIG, Medicare pays more than $1.6 billion per year for procedures performed by more than 3,000 ASCs. ASCs must become Medicare-certified by a state survey and certification agency or privately accredited to show that they meet the conditions of participation. The overwhelming majority of ASCs choose to become certified by state agencies, according to the OIG. ■

Internal investigations

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by a variety of external factors, including government audits, *qui tam* or other lawsuits, newspaper articles, and search warrants or investigative demands.

In other instances, he says, providers may have to perform an internal audit because of news reports that a major competitor with similar business practices is under investigation. Other internal triggers can include internal audits, calls to your hotline, or complaints by employees.

"It is very important to take a complaint by an employee seriously," says Litt. "You want to at least look at it and let the employee know you are doing something about it."

According to Litt, a well-organized compliance program can help providers decide when to conduct an investigation and how to structure it. A set of procedures that establishes triggers for an internal investigation also can help guide the investigation, he says.

"If you rely on pre-existing rules in deciding whether or not to conduct an investigation, you are less vulnerable to somebody saying you were trying to sweep something under the rug, because you can point to procedures," he adds.

A set of established procedures also will prevent ad hoc, crisis-driven decision making. "If you are making all of these decisions on-the-fly, in the

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face of newspaper articles, you are more likely to make the wrong decision than if you have figured out in advance how to conduct an internal investigation," he explains.

The fundamental goal of an investigation is to find out what happened, Litt says. First, you want to find out if there is a problem at all, he says. Then you want to estimate the size of the potential liability. "You can't know how much money you may have to pay as a result of the problem until you have done an investigation to figure out the scope of the problem," he says.

Litt says providers also have a fiduciary responsibility to shareholders to try to protect the corporation in every way possible by dealing with wrongdoers. "If you have bad apples, you will want to get rid of them," he asserts.

Then you'll want to fix the system so it does not happen again. That includes both disciplinary actions and new processes and controls, if necessary. "At the stage where you are negotiating with a government agency, it is a very helpful thing to be able to say, 'Here are the steps we have taken to make sure it does not happen again,'" he adds.

According to Litt, an effective investigation also will help companies defend themselves against an investigation or litigation by controlling the flow of information to the government. He says there are legitimate steps that can be taken to make sure the government gets all the facts you want them to have in addition to the facts they get on their own.

Performing your own internal investigation also will help you keep track of what the government knows and what it is learning from its investigation. "I can't tell you how important it is to know what the government knows," he asserts. "There is nothing more embarrassing than having a lawyer go to a prosecutor and make a pitch based on certain facts and having the prosecutor present evidence that undercuts your assertions."

An internal investigation also will help companies present the facts in the most favorable light, not only to the government but also to the public. "It is a fact of life that many of these investigations are accompanied by a lot of publicity," he explains. "Companies are going to want to get their own side out."

Another goal of an internal investigation is to maximize the opportunity to protect the institution by using the attorney/client work-product privilege. The work product applies not only to communications between lawyers and clients but to the lawyer's work. However, in order for the work product privilege to apply, the lawyer's work has to be in anticipation of litigation, Litt adds.

A final goal of an internal investigation is to minimize the consequences of whatever wrongdoing took place. "You want to avoid or prevail in shareholder or *qui tam* litigation," says Litt. Companies also may be able to convince the government not to proceed with a case or minimize the sentence under U.S. sentencing guidelines. Voluntary disclosure may also help prevent suspension or disbarment, he adds. ■

HIPAA myths

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Sadauskas, an information systems technologist with Northrop Grumman Information Technology, Health Solutions, and Services, both members of HFMA's HIPAA External Task Force.

Here are six myths surrounding business office and information system functions they say hospitals must guard against:

♦ **Myth: Providers won't be able to call patients with appointment reminders.**

Sausser says contacting patients with appointment reminders, information about treatment alternatives, or other health-related benefits is permissible as long as the provider first discloses its intentions to communicate with the patient. A separate statement disclosing these intentions must be included in the required Notice of Privacy Practices that is given to each patient upon his or her initial visit, she adds.

♦ **Myth: Providers will need a new consent every time a patient comes in for treatment.**

Sadauskas says the privacy guidance clarifies that "a health care provider needs to obtain consent from a patient only one time." It also adds the following: "This is true regardless of whether there is a connected course of treatment or treatment for

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unrelated conditions. A provider will need to obtain a new consent from a patient only if the patient has revoked the consent between treatments."

♦ Myth: Providers won't be able to bill if a patient revokes consent.

"Some providers have been alarmed by the privacy rule provision that permits a patient to revoke his or her written consent to use and disclose personal health information," says Sadauskas. "This raises the specter of patients revoking their consent immediately after treatment but before payment."

However, he notes that the privacy rule also states that such revocation is not effective with respect to actions taken in reliance on the consent. In other words, the provider has not violated the rule if it made a permitted good-faith use or disclosure of personal health information before becoming aware of the patient's revocation.

The privacy guidance further clarifies that, after a patient has revoked consent, providers still may bill for services that were provided before the revocation, he adds.

♦ Myth: Physicians won't be able to sell their practices.

According to Sausser, some physicians have worried that HIPAA will hinder them if they seek to sell their practices because they must share a certain amount of protected health information with the potential buyer. But she says the privacy rule includes an exception for such due-diligence activities.

"Permitted disclosures that are considered part of health care operations include the disclosure of personal health information for due diligence to a covered entity that is a potential successor-in-interest," she says.

♦ Myth: HIPAA technology is the information technology department's responsibility.

Although information technology plays an integral role throughout the HIPAA regulations, HIPAA is more an administrative compliance function than anything else, Sadauskas says. Even the security rule contains a substantial number of administrative requirements.

"Unfortunately, because policies, procedures, and risk assessments take a great deal of time and effort to develop, many providers are jumping to purchase technical tools instead of first concentrating on developing sound policies and procedures based upon their own unique circumstances and relationships," he says.

♦ Myth: HIPAA requires encryption and biometrics.

According to Sausser, some people believe that to ensure security, all health information will have to be encrypted. In fact, only health information sent over an open electronic network needs to be encrypted, she says.

Sausser says a related myth is that all staff will need to carry smart cards or have biometric access to computer files. "In reality, the proposed security rule is both scalable and technology-neutral," she says. "Biometrics are put forth in the regulation only as an example of a form of authentication that a covered entity may choose to use."

To read common myths that people have used to delay their implementation activities and addressed treatment-related issues, go to www.hfma.org/publications. ■

OIG cites increase in documentation errors

The Health and Human Services' Office of Inspector General (OIG) reports that improper Medicare benefit payments made during FY 2001 totaled $12.1 billion, or about 6.3% of the $191.8 billion in processed fee-for-service payments reported by the Centers for Medicare & Medicaid Services. The percentage of improper claims due to medically unnecessary services held steady from the year before at 43%. However, the percentage due to documentation errors increased from roughly 36% to 43%, and the percentage due to coding errors crept up from about 15% to 17%.

"Documentation errors represented the largest error category in three of the last six years," reports the OIG. "For FY 2001, the dollar amount of these types of errors increased by almost 20% compared with FY 2000, and they remain a significant problem, accounting for an estimated $5.1 billion in improper payments."

The OIG estimates that the $12 billion in improper payments is almost half the $23.2 billion that it first estimated for FY 1996. ■