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One-day stays loom as OIG's next national initiative

Several government agencies are involved in the growing number of investigations

In an effort to recoup billions of dollars it claims were improperly paid for unnecessary admissions, the Health and Human Services' Office of Inspector General (OIG) is busy reviewing and contesting prior-year claims for one-day hospital stays in various states. Health care attorney **Linda Baumann** of the law firm Reed Smith in Washington, DC, says these investigations are looking at claims dating back as far as 1992 and show all the trademarks of a national initiative.

While the initiative has never formally been designated as a "national project," Baumann points out that the $1 billion that Medicare reportedly spends each year on unnecessary hospitalizations far exceeds the amount spent on DRG upcoding.

Former OIG attorney **Julie Kass**, now with Ober Kaler in Baltimore, points out that the OIG has listed "one-day hospital stays" as a top priority in its Work Plan for the past several years. According to its most recent Work Plan, approximately 10% of all Medicare patients admitted to hospitals are released the following day.

Despite the relatively low visibility of the government's investigations into one-day stays, Baumann says there are numerous signs the government is investigating this issue at hospitals nationwide. She says that makes it critical for

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OIG releases draft guidance for ambulance providers

The Health and Human Services Office of Inspector General (OIG) released a draft compliance program guidance for ambulance providers June 6 that offers these companies considerable flexibility. "The OIG recognizes the variation among ambulance suppliers to highlight its view that compliance programs should be tailored to the individual ambulance supplier's situation and needs," says attorney **Howard Young** of the law firm Arent Fox in Washington, DC.

In fact, the guidance "goes on at length" to acknowledge that the ambulance industry is an "incredibly diverse" assortment of small and large

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On-call physicians become EMTALA hot button

How to handle the on-call physician requirement in the Emergency Medical Treatment and Labor Act (EMTALA) is a vexing question that many hospitals are grappling with. It also is a question that likely won't be solved by the proposed changes to the anti-patient dumping regulations released last month by the Centers for Medicare and Medicaid Services (CMS), argues **Lowell Brown**, a partner with Foley and Lardner in Los Angeles.

Currently, the statute provides that, as part of its Medicare provider agreement, a hospital must have an on-call panel representing the specialties available on the medical staff to treat patients who come to the emergency department, Brown explains.

The problem is that there is no legal obligation on physicians, he says. Hospitals often address this problem through medical staff bylaws that

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One-day stays

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hospitals to take proactive steps. **(See related story, this page.)**

Like most national investigations, this one appears at the outset to be centered in several states. Many New Jersey hospitals have been contacted by government agents investigating this issue, and several hospitals in that state already have settled False Claims Act cases for amounts ranging from $450,000 to more than $2 million. Numerous other hospitals currently are in negotiation with the OIG and the Department of Justice, Baumann reports.

To date, these investigations generally have proceeded at a fairly slow pace, often beginning when a midlevel manager receives a request for approximately 30 records from an OIG investigator, Baumann says. "While not denominated as such, the records are fairly readily identifiable as those involving one-day stays," she reports.

Baumann says the hospital may receive further additional correspondence from the OIG several months later, indicating the hospital's error rate on the sample, the total number of one-day stay cases for a designated time period, and an extrapolated amount of damages for this time period based on the error rate identified.

"In some instances, the error rate cited by the OIG for these one-day stays has been as high as 80% or 90%," Baumann reports. Nevertheless, she says OIG agents typically have proceeded in a "low-key" manner, often giving hospitals several months to prepare their response and rarely mentioning potential liability under the False Claims Act initially.

Hospitals should not assume there is no risk of exposure. After the error rate is calculated, the U.S. Attorneys Office typically is brought in to start discussing False Claims Act liability. Baumann says reviews of the one-day stay issue by the intermediaries and peer review organizations (PROs) appear to be operating concurrently. However, these investigations appear to be focused more on current claims.

According to Baumann, hospitals may receive a request for records from the U.S. Attorneys Office, the PRO, or both, and will be asked to return any overpayments identified. While there may be no further action taken, she says there is always the possibility that the intermediary or PRO will contact the OIG or other enforcement agency if the number of errors or volume of damages is sufficiently large or if a suspect pattern or other questionable activity is identified.

Baumann says that, while PROs do seem more focused on current claims, if a significant error rate is identified, the potential for review of prior-year claims still exists. She adds that the PROs became particularly active in this area when their Sixth Scope of Work included one-day stays as part of the Payment Error Protection Program and indicated that the PRO's performance was to be evaluated, in part, on the reduction of payment errors within their jurisdiction. ■

Protect your hospital from one-day stay investigations

In light of the government's burgeoning investigation into "one-day stays" and other transfer and discharge issues, health care attorney **Linda Baumann** says it is critical for hospitals to review their policies and procedures, and consider auditing in this area to minimize the risk of significant exposure.

According to Baumann, of the Washington, DC, office of Reed Smith, hospitals have struggled

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with the Centers for Medicare & Medicaid Services' (CMS) definition of "inpatient" for years. "The judgment as to whether or not to admit a patient to a hospital often requires complex clinical decision making, and the applicable regulations are ambiguous, leaving substantial discretion to the admitting physician," she explains.

Further complicating matters is the fact that until very recently, almost no additional guidance was available from CMS, the fiscal intermediaries, or the peer review organizations (PROs, recently renamed quality improvement organizations), she adds.

Here are six steps hospitals can take to mitigate the potential damage of these looming investigations:

♦ **Update policies and procedures.**

"Hospitals clearly need to ensure that their procedures related to billing for patients who spend less than 24 hours in the hospital are updated to reflect current laws and regulations," says Baumann. She says affected hospital staff should review all correspondence and other publications from CMS, the intermediary, and the PRO on this issue, including those documents pertaining to observation status as well as criteria for inpatient admission.

Most of these organizations have issued various documents on this subject over the past year, including newsletter articles, Q&As, utilization tip sheets, and other checklists that can help hospital personnel make the often difficult judgments as to whether a claim should be billed as an inpatient admission, she adds.

♦ **Educate physicians.**

According to Baumann, physician education is particularly important since physician judgements and documentation are essential to justify an inpatient claim for a one-day stay. Several PROs publish guidance materials specifically directed at physicians, she notes.

♦ **Contact PRO or intermediary for advice when necessary.**

Baumann says that if questions remain with regard to a particular claim, staff should try contacting the PRO and/or the intermediary for advice. Staff should also document the person contacted and the advice received, she adds. Baumann also notes that PRO staff reportedly have been increasingly responsive to queries on this subject in light of its importance to the Payment Error Protection Program.

♦ **Establish an audit schedule.**

Baumann reports that a number of hospitals are so concerned with this issue they have implemented procedures to require pre-bill manual review of all one-day-stay claims. "Depending on your facility's size and resources, review of all such claims may not be feasible," she says. "Nevertheless, monitoring a certain number of these cases on a regular basis before they are billed would seem advisable."

At a minimum, Baumann says this type of claims should be audited at least once a year and perhaps more often depending on the error rate identified. If the current error rate is high, she says hospitals may want to consult legal counsel and consider a retroactive audit.

♦ **Stay alert to government inquiries.**

"Stay on the alert for indications that the government is investigating your facility's prior-year claims for one-day stays," Baumann advises. She says any hospital employee who is contacted or receives a request for records from the government on this issue should be instructed to promptly contact their supervisor and/or the compliance officer.

♦ **Perform your own analysis of alleged errors.**

Any "errors" subsequently identified by the government should be reviewed closely since these may be subject to challenge, Baumann says. For example, she says clinical standards with regard to certain medical conditions and procedures may have changed, and cases that should be billed as outpatient in 2002 may well have qualified as inpatient claims in prior years.

"If the error rate identified by the government is low or if you are able to reduce it sufficiently, the matter may end with the return of identified overpayments," says Baumann. However, if a substantial error rate leads to government allegations of false claims liability, she says numerous potential defenses can be considered. "With so many government agencies focused on this issue, it will be important to keep one-day stays on the radar screen for the foreseeable future," warns Baumann. ■

Draft guidance

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companies, for-profit and not-for-profits, independent and provider based, municipal and private, says Young, one of the primary authors of the guidance when he was with the OIG.

That said, ambulance providers should study the guidance carefully, Young recommends. In recent years, federal and state fraud and abuse enforcement authorities have hotly pursued ambulance companies for alleged billing fraud on the Medicare and Medicaid programs.

"Kickback arrangements have also been an area of enforcement concern," says Young, noting numerous criminal prosecutions involving ambulance suppliers and the "intense interest" in obtaining OIG advisory opinions on ambulance restocking programs.

According to AAA's attorney, **Darrel Grinstead** of Hogan & Hartson in Washington, DC, the new element in the draft guidance is its attempt to identify specific compliance risks associated with services covered under the Medicare program. In particular, the guidance attempts to take into account the new requirements in the Medicare ambulance fee schedule and to provide not only an interpretation of those requirements but also suggestions for ambulance suppliers to operate in compliance with the new requirements.

"While this will be a useful tool when it is complete, this draft needs to be reviewed very carefully to ensure that it is consistent with guidance from the Centers for Medicare & Medicaid Services on the same issues and that the guidance is reasonable from a practical, operational standpoint," he says. The association has identified several points where the draft guidance differs from recent guidance published by CMS, he adds.

According to Grinstead, the draft guidance also briefly discusses Medicaid compliance issues and sets forth a detailed discussion of the applicability of the anti-kickback rules to ambulance services. "The discussion provides no new guidance in this area, but it does provide a useful summary of the OIG's views on the compliance issues raised by the anti-kickback statute and regulations," he explains. ■

EMTALA regs

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include this as a condition of membership on the medical staff. "One of the requirements for being a member of the average hospital medical staff is that you have to take calls," he explains. "If you don't take calls, you can't be on the staff."

The legal obligation to have and enforce a call panel still rests with the hospital. However, physicians do have an obligation once they are on call.

According to Brown, the central issue is whether calls should be mandatory or voluntary for medical staff members. Brown says the proposed regulation tries to address this issue through the following three-sentence rule:

- Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients.
- Physicians, including specialists and sub-specialists, are not required to be on call at all times.
- The hospital must have written policies and procedures in place to respond to situations in which a particular specialist is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

While that may be music to physicians' ears, it does not solve the problem, Brown argues. In fact, it might even create more confusion because physicians who do not want to take calls may read it as evidence that they do not have to. "I don't think CMS intended that, but the language is ambiguous," he asserts.

According to Brown, the only current solution is for the hospital staff and medical staff to share the burden. "As long as there is a will for both sides to work together, the pain can be spread so that nobody is bearing all of it," he says.

Brown says there are several ways to accomplish that. For example, in the latest regulation, CMS has approved the use of call schedules that leave significant discretion with hospitals to design call panels that fit both patient needs and the composition of their medical staff. "If you have a town with five hospitals and two neurosurgeons, it is a terrible myth to think those two neurosurgeons have to be on call 24 hours a day, seven days a week," he explains. ■