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OIG releases model compliance plan for HHAs

The model compliance plan released Tuesday was a familiar version of the one the OIG prescribed for hospitals, but there were one or two surprises. Home health agencies must ensure their services are medically necessary, as well as verify that the physicians they work with are properly licensed. In this respect, they now will have to operate much like hospitals.

"[The plan] is voluntary guidance designed to help companies prevent fraud, waste and abuse by promoting a high level of ethical and lawful corporate conduct," says HHS Inspector General **June Gibbs Brown**.

The home health plan is not designed for durable medical equipment outfits, which will probably get their own plan by next spring. Another plan for third-party billers should be out in the fall, according to Brown.

The plan itself is fairly similar to its predecessors. It, too, is based on seven fundamental tenets, including implementing written policies and standards of conduct; designating a compliance committee and compliance officer; training employees in compliance; creating communications channels such as hotlines; enforcing well-publicized disciplinary guidelines; conducting internal audits; and quickly investigating and correcting violations. The home health plan also calls for providers to report violations to OIG within 60 days after an internal investigation has discovered credible evidence of a problem.

But there are some special provisions that may discomfit some HHAs. For one, OIG is thrusting responsibility for verifying medical necessity upon

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Breaking news

HCFA to require home health compliance plans

On Friday, the Health Care Financing Administration weighed in on the issue of home health compliance. According to HCFA deputy administrator **Michael Hash**, the agency will make having a compliance plan in place a condition of participation in the Medicare program. No word yet on whether HCFA will require compliance plans for other health care entities. ■

Hospital settles pharmacy false claims for $4.3 million

In an unusual case, an Atlanta hospital has just paid $4.3 million to settle a whistle blower suit. **Craig Heyrman**, the former pharmacy manager for Grady Memorial Hospital, claims the hospital overcharged the Georgia Medicaid program for prescriptions. He collected $779,000 for blowing the whistle.

As a nonprofit provider, Grady was supposed to bill Medicaid for the actual acquisition cost of the drug, plus the statutory dispensing fee, according to the suit. But between 1984 and 1994, Grady charged a usual and customary dispensing fee on top of the statutory fee.

Between July 1992 and December 1994, for example, Grady billed a $7.50 usual and customary fee on top of the $4.11 statutory dispensing fee, Heyrman says. That resulted in $3.3 million in overcharges on 450,000 claims during that period, according to the suit. The problem began when

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HHAs. "Although it is a physician who determines medical necessity, a home health agency has an obligation to ensure that services it provides are medically necessary, and should consult with physicians as appropriate for the requisite assurances," says the model plan. That could be a booby trap, says **Bill Sarraille**, an attorney at Arent Fox in Washington, DC. "On what basis is an HHA supposed to challenge a physician?"

In addition, an HHA is expected to take "reasonable measures" to verify that a physician has an appropriate license and hasn't been criminally convicted, disbarred or excluded. They're also expected to conduct criminal background checks of prospective employees and avoid dealing with parties excluded by Medicare. Yet, interestingly, OIG itself appears unsure of the ability of HHAs to devise a compliance plan, the cost of which can range from $25,000 to $500,000, depending on the size of the provider. The model plan recommends HHAs use outside contractors to help build or enhance a provider's compliance program.

Its other recommendations include:

Pay special attention in the compliance plan to areas OIG has identified as prone to fraud. These include

- billing for services not rendered;
- billing for medically unnecessary services;
- duplicate billing;
- false cost reports;
- not returning overpayments;
- paying or receiving incentives to refer patients;
- billing for patients who are not homebound;
- overutilization or underutilization;
- inadequate care;
- insufficient documentation to back claims;
- billing for unallowable costs;
- unqualified personnel;
- backdating of nursing notes;
- falsified plans of care;
- untimely or forged physician certifications of plans of care and forged beneficiary signatures;
- high-pressure marketing;
- inadequate oversight of subcontractors;
- discriminatory admissions and discharges;
- volume-based compensation;
- hospitals referring patients to HHAs they own.

Pay special attention to areas where the HHA has already had problems. If OIG catches you again, they won't be merciful.

Have caregivers confirm by signature that nursing notes are correct. Also include prompts on nursing note forms to encourage employees to verify homebound status. These might include questions such as, "Does the patient ever leave the home, and if so, where does he go and how often?"

Maintain a hotline, or if that's not feasible, allow employees to report problems anonymously through drop boxes, e-mail or other means.

Include compliance as a factor when doing job reviews. Pay particular attention to potential hot spots such as claims submissions and cost reports as well as relationships with other providers that might violate the anti-kickback and Stark laws.

Conduct multilingual compliance training for employees, if need be. Training should focus on such areas as improper alteration of clinical records, patient rights and compliance with Medicare conditions of participation.

Meanwhile, OIG is taking note of criticism that the process of designing its model plans is too secretive. When creating future plans, the agency will first put a notice in the *Federal Register* soliciting public input on what should be included in each plan. ■

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OIG updates laboratory compliance plan

In addition to issuing its home health plan, the OIG has updated its model compliance plans for clinical labs. The biggest change is removing requirements regarding automated multichannel chemistry tests (CPT codes 80002-80019).

Labs will no longer have to worry about educating physicians about automated tests. For example, the new model plan no longer requires labs to write requisition forms so doctors would have to order tests individually. The new plan merely calls for the form to ask that a doctor "has made an independent medical necessity decision with regard to each test the laboratory will bill."

Nor will annual notices sent to doctors by labs have to break down the individual components of every multichannel test. However, labs still must remind physicians of Medicare policies on lab tests and the consequences of filing a false claim.

In other ways, the lab model plan has been brought into line with newer plans for hospitals and home health agencies. A major change is that OIG has dropped the controversial standard of requiring self-disclosure within 60 days after the receipt of the credible evidence of misconduct.

In the updated plan, the clock starts ticking after you have had time to conduct an internal investigation, rather than beginning immediately after an employee reports a suspicion of misconduct.

An important addition concerns Advanced Beneficiary Notices, which tell beneficiaries that they may have to pay for a service that might be denied. The agency recommends labs educate physicians on the use of ABNs, which must specifically list the service in question and why Medicare might not pay.

Other changes in the new plan include:

- **Expanded duties for lab compliance officers.** Compliance officers should review requisition forms and other documents that support claims, as well as check lab forms that doctors and others use to order tests.
- **Obtaining diagnoses.** Labs should ask doctors to provide diagnostic information when ordering tests, says OIG. Even though physicians should be doing that routinely for most tests, it's important for labs to ask for the data because they are obligated to produce documentation to support medical necessity.
- **New employees.** New hires should sign a statement certifying they have read and understood the lab's standards of conduct.
- **New ways of obtaining data.** The plan states that additional information, such as diagnosis data from the medical record, "can be obtained from an authorized person on the physician's staff rather than directly from the physician."
- **Physician's discretion.** The new plan makes clear that doctors can order whatever tests they deem appropriate. But Medicare will only pay for those that are covered, reasonable and necessary. ■

GAO continues criticism of HCFA's fraud efforts

HCFA's fraud control measures continue to draw fire from the General Accounting Office. Congress' watchdog agency has issued yet another report (HEHS-98-215R) that points out weaknesses in Medicare fraud controls by carriers and fiscal intermediaries, which are supposed to get more money under the HIPAA legislation.

"Despite fiscal year 1998 budget increases, contractors we visited have not increased their staff involved in program safeguard activities, such as provider audit and claims reviews," the report notes. In turn, contractors are reluctant to beef up their audit programs because they aren't sure of how much anti-fraud money they will get from HCFA, says GAO.

HCFA didn't notify carriers and intermediaries of their FY 1998 funding until four months into the fiscal year, and now "contractors' staffing for some important program integrity activities is now less than it was before HIPAA," according to the study. Nor has HCFA coordinated audit programs among different carriers, so controls successfully developed by some haven't been copied by others.

One solution would be an on-line claims processing system. Too bad that HCFA's planned Medicare Transaction System was scotched because of delays and overruns. Nor will shifting patients to managed care help, because HCFA's oversight of HMOs has been weak, says GAO. ■

Whistle Blower

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Grady installed a computerized billing system in 1984, Heyrman says.

Not surprisingly, the hospital has a different story. "It was a computer glitch," says hospital attorney **Alan Rosenberg**. A programming error added the second prescription fee, says Rosenberg, who argues the settlement was light given that it covered 10 years worth of claims. "It was essentially a payback of an overpayment plus interest," he adds.

Grady was confused by unclear Medicaid rules, says **William Mitchelson**, an attorney at Atlanta-based Alston and Bird, which represented the hospital. Grady had unsuccessfully sought guidance from Georgia Medicaid, and had billed according to what it thought the state wanted. Mitchelson says Grady already was discussing the billing problem with Medicaid before Heyrman filed his suit.

Rosenberg also questions Heyrman's role in the affair. "He was the director of pharmacy reimbursement," Rosenberg says. "He signed off on the claims."

Heyrman argued that he had repeatedly warned the hospital of the overcharging. Grady did not admit any wrongdoing in the settlement.

During the period of the overcharges, Grady had "pieces of a compliance plan," Rosenberg says. Like many providers, Grady is now in the midst of creating a formal compliance plan. And that should be a lesson for all providers to create a compliance plan, Rosenberg warns. "It's like having a risk management system." ■

Columbia/HCA execs face more federal charges

Federal prosecutors are turning up the heat on Columbia/HCA. In the latest move, a Tampa, FL, grand jury has levied more indictments on several Columbia hospital executives already facing charges.

The superseding indictment accuses the managers of attempting to impede a federal auditor as well as making false statements to obtain Medicaid benefits. Those indicted are: Jay A. Jarrell, CFO of Columbia's Southwest Florida division; Michael T. Neeb, CFO of the Jacksonville division; Robert W. Whiteside, reimbursement director for Columbia hospitals nationwide; and Carl Lynn Dick, CFO of the Central Florida division.

While Dick is a new defendant, Jarrell, Neeb and Whiteside were previously indicted in June 1997 for filing false cost reports to Medicare and CHAMPUS. The reports were allegedly filed on behalf of Fawcett Memorial Hospital, Port Charlotte, FL, from 1986 to 1997. The defendants are accused of listing interest payments on Fawcett's long-term debt as pure capital expenditures, which command a higher reimbursement rate from Medicare. In reality, only 39% were capital expenditures, with the remainder going for other expenses such as salaries, according to the government.

The Columbia managers allegedly failed to notify the fiscal intermediary that it had made an auditing error that allowed approximately $2.7 million in improper interest rate deductions to continue. It's also alleged that, in 1994, Jarrell, Neeb and Whiteside participated in a meeting to discuss whether to make "an attempt to influence the auditor with an offer of employment, if necessary."

The government also has alleged that Columbia created a reserve fund specifically earmarked to return overpayments should its error be discovered. In addition, the defendants allegedly misrepresented facts in order to get a favorable legal opinion regarding their activities.

Columbia spokesman **Jeff Prescott** declines to discuss the specifics of the case, but does say the indictments are "not a surprise." He adds that prosecutors had previously said they might seek additional indictments in the Florida case. The four executives currently are on paid leave.

Prescott also declines to confirm numerous reports that settlement talks have long been underway between Columbia and the Justice Department. However, he says, "Our lawyers have been talking to them every day." Columbia routinely notifies DOJ of business decisions, such as the recent announcement of a $1 billion stock buyback. "We don't want to surprise them with any of our business decisions," Prescott adds.

Columbia also is stepping up the pace of its newly expanded compliance program. Standards of Conduct as well compliance training tapes were recently distributed to employees, Prescott says. ■