COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

MONDAY
MARCH 22, 1999

Nurse nails Univ. of Chicago in *qui tam* suit

Hospital's liability could reach $100 million, some experts project

A private whistle-blower has latched onto the government's investigation of teaching hospitals. The University of Chicago Hospital has been sued by a former employee whose charges mirror those leveled by OIG in its PATH (Physicians at Teaching Hospitals) initiative.

Linda Wawzenski, the assistant U.S. attorney in Chicago handling the case, dismissed reports in local papers that the hospital's liability could reach $100 million. That would far exceed the $30 million paid by the University of Pennsylvania in the largest of the half-dozen PATH settlements. **Steven Cohen**, the Chicago attorney representing whistle-blower Al Reppine, says the hospital may have improperly billed Medicare and Medicaid for as much as $15 million to $20 million, but Wawzenski says that even $10 million "is on the high side." Still, the triple damages allowed by the False Claims Act could potentially put a settlement at $30 million, and that doesn't even count any $10,000-per-claim penalties.

Reppine, a former nurse at the hospital, makes the same claims of upcoding and improper physician supervision that OIG made in its PATH investigations of other institutions. A staggering 40% of the highest-coded outpatient physician Evaluation and Management codes were upcoded by one to four E&M levels, according to the Justice Department complaint. "In at least one of the defendants' medical departments, doctors were only given the option of charging the two highest codes for outpatient services for Medicare patients,

See **Chicago suit**, *page 4*

New surety bond reg will prune HHAs

Home health agencies (HHAs) will be heartened to learn that HCFA has accepted recommendations in a General Accounting Office report that calls for a less expensive bond than originally proposed by HCFA. But many HHAs would still find it difficult to meet even the milder HCFA requirement for bonds.

Under HCFA's original bond reg, which would have required HHAs to obtain a bond of $50,000 or 15% of their Medicare revenues, a staggering 60% of home health agencies could not have met the

See ***Surety bond***, *page 4*

New monetary penalty reg threatens nursing homes

Late last week, the Health Care Financing Administration unveiled a wicked weapon against nursing homes that experts say could jeopardize patients' health and safety. In the March 18 *Federal Register*, the agency announced a regulation that allows it to impose Civil Monetary Penalties (CMPs) of up to $10,000 for each serious incident of fraud or abuse that it finds.

CMPs have become the government's tool of choice for enforcing laws such as the anti-kickback statute. They're administrative penalties that, unlike a False Claims Act suit, don't require the Office of the Inspector General or HCFA to convince a federal prosecutor to file a court case. That makes them quicker and cheaper for regulators to impose, which has sparked worries that CMPs will rain down on providers.

The new penalties will be levied per each incident, and will be in addition to the current system

See ***Monetary penalties***, *page 2*

Monetary penalties

Continued from page 1

of imposing fines based on the number of days that the facility was out of compliance. The value of the CMP will be based on the severity of the incident (particularly if a resident was harmed), the facility's culpability, and its history of prior offenses. While nursing homes can dispute the penalty in an administrative court, "regulators do not have to wait until a violation is fixed to assess a penalty," asserts a HCFA statement. "In addition, nursing homes will not have an opportunity to avoid such fines by fixing the violations that led to their imposition." The regulation takes effect May 17; HCFA is accepting public comments until that date.

In addition to per-incident fines, HCFA says it's also considering imposing CMPs based on the number of days of non-compliance. Unlike the current per-day penalties, surveyors would not have to determine the exact date on which the facility returned to compliance before calculating a fine. So, for example, surveyors who found a nursing home out of compliance during inspections on June 1 and July 1 could automatically impose a 30-day CMP at a stiff $3,000 to $10,000 per day. HCFA says its goal is to cut down on the number of visits surveyors must make to assess penalties.

Penalties based on the number of serious incidents could be more costly than fines that are based on the number of days of non-compliance, says **Scott Parkin**, spokesman for the American Association for Services and Homes for the Aging, in Washington, DC. Parkin also questions whether beefing up penalties will strengthen patient care, or just suck up money that nursing homes could use to improve their services. "The idea of slapping their wrists may not be the most efficient way," he adds.

Regardless of the penalty, what is most important is how aggressively the penalties are used, says **Mike Mustokoff**, a Philadelphia attorney who has represented nursing homes in several False Claims Act suits. How nursing homes will fare depends, for example, on how stringently HCFA defines an incident of serious patient abuse.

Regardless of what HCFA does, the "lion's share" of nursing home enforcement will continue to be done by states, notes Mustokoff. And on top of fines, the regulation also imposes tougher state inspections, a move that HCFA attributes to lackadaisical enforcement in some states. Current regs mandate that complaints involving immediate jeopardy to patients be investigated within two days, and all other complaints "in a timely manner." Now, the time limit is 10 working days to investigate all complaints. HCFA Administrator Nancy-Ann DeParle promises to impose minimum federal standards for state investigations as well as tighter federal monitoring of state performance.

Industry experts say they're still studying the regulation, a final rule that will take affect later this year. But some eyebrows have lifted at the fact that HCFA unveiled the regulation the day before the release of a new GAO report on HCFA and nursing homes. "I don't know, but it sounds like a really good coincidence," laughed one Congressional staffer familiar with the nursing home issue. GAO found that the majority of HCFA sanctions were never imposed. The result is a ping-pong game where nursing homes under a threat by HCFA correct deficiencies, HCFA then withdraws the sanctions, and the facilities backslide to their old ways. Beside fines and tighter state enforcement, other planks of HCFA's new nursing home platform include:

♦ Making public results of state inspections on a Web site called Nursing Home Compare at www.medicare.gov. Nursing homes already have to make the results known to residents who

Compliance Hotline™ is published every two weeks by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. *Compliance Hotline™* is a trademark of American Health Consultants®, a Medical Economics Company.

SUBSCRIBER INFORMATION
Please call **(800) 688-2421** to subscribe or if you have fax transmission problems. Outside U.S. and Canada, call **(404) 262-5536**. Our customer service hours are 8:30 a.m. to 6:00 p.m. EST.

request them, but the Web site will contain, "the most recent information from state inspections of every Medicare- and Medicaid-certified nursing home in a consumer-friendly format, as well as location, size, and ownership," according to HCFA. However, Parkin says this is nothing new because the site has been up for months.

♦ Launching new public awareness campaign to teach residents, their families, and those who work with residents how to spot neglect and abuse. ■

Health systems fear ruling on nursing homes

The Office of the Inspector General's concern with preventing nursing home kickbacks may have thrust a stake into the heart of the nursing home prospective payment system (PPS). Some hospital systems that run nursing homes are now scrutinizing the arrangements made by their skilled nursing facilities (SNFs), after a new OIG anti-kickback advisory opinion that frowns on ambulance discounts offered to nursing homes.

In light of the new information, **Alice Guttler**, general counsel for Centrastate Healthcare System in Freehold, NJ, says she will be reviewing the contracts of Centrastate's nursing home to make sure they don't raise red flags at OIG.

What's prompted this fuss is Advisory Opinion 99-2, which concerns ambulance transport for SNF patients. SNF reimbursement for ambulance service is now included in the fixed per-diem PPS payment system, which Congress mandated in the Balanced Budget Act of 1997 as a way of encouraging nursing homes to cut their costs.

In this case, a nursing home proposed a deal that would seem to meet the government's desire. It would slash its expenses by entering into an agreement with an ambulance company, which would offer discounts of up to 50% of the Medicare reasonable charge for basic and advanced life support.

While the nursing home would pare its transport costs, the ambulance company would enjoy some savings because it could present a single, consolidated bill to the SNF.

OIG didn't buy it. The regulators concluded that the deal might constitute a kickback if there was an intent to induce referrals. What the agency homed in on was the possibility that a nursing home that offered steep discounts for transport of PPS patients might be bribed into referring other business to an ambulance company.

"We are unable to exclude the possibility that Ambulance Company X may be offering improper discounts to the Nursing Home and other SNFs for their PPS-covered Part A business with the intent to induce referrals of more lucrative Part B business," notes the OIG opinion.

As the agency sees it, this deal raises the specter that a nursing home is seeking discounts on PPS patients, for whom it bears all of the financial risk under a fixed-price system, in return for referring to the ambulance company its Part B patients, for whom Medicare picks up reasonable costs.

Even a SNF that doesn't purposely steer patients to a single contractor might end up doing so accidentally, OIG concludes. "SNF personnel may not always know which patients or transports will be covered by PPS when the services are ordered," notes the advisory opinion. "In these latter circumstances, the simplest way for a SNF to ensure that it is using its contracted provider for its PPS patients — and therefore securing the Part A discounts — is for the SNF to refer most patients to that provider."

OIG also dashed any hopes that the deal would be protected by a discount safe harbor in the anti-kickback statute, on the grounds that Medicare and Medicaid as well as the SNF must receive the discounts from the ambulance company.

The agency's analysis has experts scratching their heads. If the purpose of the prospective payment system for SNFs is to encourage them to cut costs, isn't it natural that they will seek discounts from contractors? "The consequence of this opinion will be that there will be a uniform pricing for nursing homes," says **Bill Sarraille**, an attorney in Washington, DC.

Nursing homes that enter contracts will have to take extra care, such as hiring consultants, to ensure that prices are at fair-market value. Guttler believes nursing homes will end up soliciting sealed bids to preclude any suspicion of kickbacks. ■

Chicago suit

Continued from page 1

regardless of the actual level of the service performed according to the CPT codes," says DOJ.

In addition, the hospital allegedly upcoded Hospital Ambulatory Reform (HAR) codes for Medicaid patients. "In 1995, HAR procedure code 00.80 accounted for 94% of defendants' clinic billings to Medicaid," says the complaint. Hospital spokesman **John Easton** would say only that the hospital denies the charges.

Yet while the government intervened in support of Reppine's claim of upcoding, it did not buy his argument that University of Chicago doctors violated HCFA regulations that require teaching physicians to actually spend time (and document the time spent) with patients under care of residents. Wawzenski declined to say why DOJ isn't supporting Reppine on the supervision issue.

The qui tam suit comes after the Justice Department announced a softer approach on false claims cases last year, and after OIG said it would not pursue PATH investigations in states where carriers gave unclear guidance on teaching physician regulations. "I assume that if the government saw a good case, they would have to go forward with it," says **Ivy Baer**, an attorney for the American Association of Medical Colleges in Washington, DC.

Wawzenski acknowledged that it is uncommon for a qui tam suit to be unsealed and made public prior to a settlement being announced. It happened in the Chicago case because the court imposed a deadline that forced the government to decide whether to intervene — and unseal the suit — or allow Reppine's suit to proceed on its own. ■

Surety bond

Continued from page 1

minimum standards that bond companies insist upon before issuing a bond, says **Bill Dombi**, vice president of health law for the National Association for Home Care in Washington, DC.

HCFA has accepted GAO's advice to drop the 15% requirement, which would have been expensive for larger HHAs, but retained a flat $50,000 bond. But even the smaller bond would result in 40% attrition, Dombi estimates.

GAO also concludes that DME suppliers, who would also need bonds, would be culled of their smaller members. "Since many DME suppliers receive very limited Medicare revenue, they may be more likely to cease participation in the program if they view the surety bond requirement as too costly," says Congress's watchdog agency. However, HCFA accepts GAO's contention that mandating providers to buy both a Medicare and a separate Medicaid bond would be redundant.

Surety bonds are supposed to indemnify HCFA against fraud and abuse by HHAs and DME suppliers who may lack the funds to repay Medicare. GAO estimates that fees for these bonds could exceed $60,000 for a large HHA, though the typical agency would pay $1,000 to $7,500.

However, GAO's research does reveal how HHAs can reduce their surety bond premiums. While premiums are 1% to 2% of the face value of the bond, according to GAO, one bond company contacted by the agency said that its rates varied between 0.5% and 3%.

"It indicated that having a written business plan describing how the agency would respond to the new payment rates created by the BBA, audited financial statements, positive cash management history, and rigorous record-keeping policies and practices reduced the HHAs' fees," according to the GAO. "In addition, the bond company said its lowest fees were charged to "nonprofit HHAs supported directly or indirectly by public or private foundations. Its highest fees were for providers new to the home health care business."

GAO also recommends that bonds only be required for new HHAs as a way to ensure that they have adequate capital. "Little may be gained from continued screening of established, mature agencies," concludes GAO. In addition, GAO wants a loophole closed in a Treasury Department regulation that allows Treasury notes to be substituted for a surety bond.

HCFA spokesman **Craig Palosky** replies that authority to make these changes rests with Congress rather than HCFA. One opponent of exempting established HHAs may be the insurance industry. Bond companies say that exempting older HHAs from bonds would only drive up the cost for those agencies that need bonds, according to the study. ■