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The Compliance Revolution *Will* Be Televised: OIG Videos Offer Practical Compliance Pointers

By Kathleen McDermott and Arianne Callender

Arianne Callender and Kathleen McDermott are resident in the Washington, D.C., office of Morgan, Lewis & Bockius LLP and represent the health industry on compliance and enforcement matters. Callender is former senior counsel with the Department of Health and Human Services Office of Inspector General and, and McDermott is a former Assistant U.S. Attorney for the District of Maryland, and a Department of Justice health care fraud coordinator. McDermott can be reached at kmcdermott@morganlewis.com; Callender can be reached at acallender@morganlewis.com

The Department of Health and Human Services Office of Inspector General's (OIG's) Health Care Fraud Prevention and Enforcement Action Team (HEAT) has garnered headlines for its coordinated Medicare fraud criminal sweeps. However, the team is not just focused on enforcement; since February, HEAT has hosted a series of compliance trainings throughout the country for compliance professionals, health care businesses, and in-house counsel.[1]

On June 8, OIG posted videos of the Washington, D.C. training on HEAT's website, http://oig.hhs.gov/heat/. In addition to a video of the complete 3-hour, 45-minute training, OIG released 16 individual modules broken down into discrete subject areas so viewers can choose which segments to watch. Presentation slides for the training and 11 related handouts are also available on the HEAT website.

These materials offer a valuable tool health care organizations can use to develop or deliver internal compliance training and to raise internal awareness of compliance. Compliance professionals will want to ensure that annual and effectiveness review efforts acknowledge these OIG materials as part of any effectiveness review.

Compliance Training Overview

The training, ''Take the Initiative: Cultivate a Culture of Compliance with Health Care Laws,''[2] features re-

[1] Sessions were held in Houston, Texas; Tampa, Florida; Kansas City, Missouri; Baton Rouge, Louisiana; Denver, Colorado; and Washington, D.C. (information is available online at http://compliance.oig.hhs.gov/enrollment.html, last visited on June 1, 2011).

[2] HEAT Provider Compliance Training Presentation, ''Take the Initiative: Cultivate a Culture of Compliance with Health

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marks from Inspector General Daniel Levinson, and offers guidance on compliance fundamentals. This is useful information for any health care business involved in federal or state health care programs.

In the training, OIG addresses the following subjects:

- Navigating health care fraud and abuse laws;
- Compliance program basics;
- How to navigate the Centers for Medicare & Medicaid Services and its partners when compliance issues arise;
- Health care fraud enforcement initiatives; and
- Effectiveness reviews.

OIG Questions to Prepare Organizations for Health Reform

To assist organizations in addressing new obligations related to health reform, or the Patient Protection and Affordable Care Act (PPACA), supplemental materials include the Inspector General's (OIG's) list of questions that compliance professionals should ask as they prepare for health reform.[3]

Organizations are already working to adjust their operations to prepare for changes such as the transparency provisions under the Sunshine law, compliance mandate for Medicare and Medicaid enrollment, and quality-driven reporting and payment initiatives under health reform.

At the same time, the government is beefing up enforcement, with some $250 million being added to its fraud enforcement funding over the next decade. CMS recently announced that it will, for the first time, use technology to predict potential fraud based on Medicare claims data.

As of July 1, CMS will deploy predictive modeling technology to flag ''problem'' claims and assign these claims risk scores. CMS will then forward suspect claims for further review or for investigation and enforcement. Thus, health care organizations are facing far greater scrutiny than ever before.

The OIG's questions can guide organizations as they assess their compliance programs and adapt their operations to this rapidly evolving regulatory environment. The questions cover three priority areas: transparency, quality, and accountability.

- Transparency questions probe the adequacy of systems and technology necessary for complying with new reporting and disclosure requirements, as well as the security and privacy protections necessary to protect underlying data, such as:
  - Does your organization have the right systems and technologies to meet new demands to collect, organize, track, retain, and report information and data accurately and completely?
  - Do you have security and privacy protections in place for creating, transmitting, and storing data?
  - Do you have systems in place to meet enhanced reporting and disclosure requirements applicable to your industry segment?
- Quality questions consider proper charting and reporting of quality of care, getting compliance departments involved in discussions and decisions about quality, the degree of quality expertise within the compliance department, and board and management awareness of the heightened role of quality of care under health reform, including:
  - Do your clinicians understand that quality is a compliance concern and that quality of care is increasingly integral to payment?
  - Do you have systems that will ensure that charting, collection and reporting of quality data and clinical documentation are accurate, complete, and sufficient to justify payment?
  - Are your board of directors and management informed about the heightened role of quality of care under health care reform?
- Accountability questions address compliance plan development; screening of individuals or businesses; risk areas associated with new payment and delivery systems (such as medical homes, accountable care organizations, and value-based purchasing); quality of care compliance obligations; and data mining to detect improper claims, including:
  - Do you have a compliance plan in place? If not, is your organization prepared to create and implement one?
  - Do you know with whom your organization does business?
    - Does your organization have affiliations with excluded, suspended, or Medicare debt-owing individuals and entities?
    - Are you prepared to meet new requirements for background and licensure checks?
  - Are you focused on identifying and addressing new fraud and abuse risk areas that may arise as your organization becomes involved with new payment and delivery systems (such as medical homes, accountable care organizations, bundled payments, and value-based purchasing)?
    - For example, are you thinking about risk areas such as inappropriate stinting on care, ''cherry picking'' patients, ''lemon dropping'' patients, gaming of payment windows, and misreporting of quality or performance data?
    - Will you have safeguards in place to address these and other risks?
    - Will compliance be part of the conversation as your organization contemplates new business and reimbursement arrangements?
  - Is your organization addressing its increased compliance and quality responsibilities under health care reform?
  - Do you have systems in place to screen for improper claims before they are filed?
    - Are you using data mining and other techniques and technologies to detect improper claims?

Compliance professionals should use these questions to identify gaps in their organization's policies or systems, and ensure that risk areas are identified and addressed.

Care Laws,'' is available online at http://oig.hhs.gov/compliance/provider-compliance-training/files/Provider-Compliance-Training-Presentationv2.pdf (last visited June 1).

[3] HEAT Provider Compliance Training Presentation Materials, ''Some Questions Compliance Professionals Should Ask as They Prepare for Health Care Reform,'' are available online at http://oig.hhs.gov/compliance/provider-compliance-training/files/HealthCareReformQsforComplianceProfessionals508.pdf (last visited June 1).

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Practical Tips from OIG

In its discussion of key fraud and abuse laws, OIG offers tips on Stark Physician Self-Referral Law and Anti-Kickback Statute compliance. Stark risk areas highlighted include documentation of financial relationships with referring physicians, lease valuations, productivity bonuses, and gifts. Anti-Kickback compliance tips emphasize the ''one-purpose test,'' which deems a payment an illegal kickback where any part of a payment is determined to be for the purpose of inducing the referral of Medicare or Medicaid items or services.

OIG also advises providers and suppliers to pay close attention to fair market value and necessity, and ensure that payments are made for services that are actually performed. Thus, organizations should not only be reviewing their agreements for compliance with Stark and the Anti-Kickback Statute, but should also track payments and maintain supporting documentation for services rendered to limit potential risks associated with these arrangements.

OIG continues to recommend that health care entities and professionals screen against the OIG exclusion list at http://www.oig.hhs.gov/fraud/exclusions.asp, make voluntary self-disclosures[4] of instances of employing excluded individuals, and maintain documentation of exclusion list searches performed on employees or contractors.

An important compliance enhancement for the provider and supplier workforce is to ensure all licensed health care professionals providing services by contract or employment remain in full licensure status. Credentialing and licensure failures can lead to overpayment liability in many circumstances.

In addition to addressing the seven fundamental components of an effective compliance program, OIG offers its own practical tips for implementing effective compliance programs:

1. Make compliance plans a priority.
2. Know your fraud and abuse risk areas.
3. Manage financial relationships.
4. Just because your competitor is doing something doesn't mean you should.
5. When in doubt, ask for help.

OIG also advises that organizations involve the board of directors in establishing compliance programs, monitoring risk areas, and developing benchmarks and goals for compliance effectiveness. The issue of board and management accountability is prominently referenced in recent OIG corporate integrity agreements (CIAs) with management accountability certifications and independent board compliance resources and compliance reviews.

The OIG CIAs continue to be an important benchmarking resource. In addition, in supporting materials addressing measurements of compliance program effectiveness, OIG instructs companies to evaluate whether the compliance program has sufficient funding and supporting.[5]

To help organizations navigate CMS, the presentation offers several useful resources, including listings of key CMS officials, maps, explanations regarding Medicare and Medicaid program contractors, and websites for CMS entities and contractors involved in program integrity or fraud detection and prevention.

HEAT Enforcement Initiative

After the prosecution successes of the Department of Justice (DOJ) and HHS Medicare Fraud Strike Force, in 2009 DOJ and HHS announced the creation of HEAT, a multiagency effort aimed at aggressively pursuing Medicare fraud enforcement and expanding Strike Forces in fraud ''hot spots'' nationwide. The initiative built on joint enforcement activity begun in 2007.

Since its inception, HEAT has established Strike Force fusion centers in nine fraud hot spots: Baton Rouge, La.; Brooklyn, N.Y.; Detroit, Houston, Los Angeles, Miami-Dade, Tampa Bay, Fla.; Dallas, and Chicago. HEAT employs state-of-the-art technology to attempt to identify fraud in real-time and uses collaborative data sharing between DOJ and HHS to track fraud and abuse patterns.

Since 2007, Strike Force efforts have resulted in charges against more than 990 individuals involving $2.3 billion in alleged false billings to Medicare. In a one-day sweep in February, the Strike Force charged 111 individuals in Miami, Brooklyn, Chicago, and Baton Rouge with Medicare fraud involving more than $225 million in alleged false billings related to home health care, durable medical equipment, diagnostic testing, physical therapy, and prescription drug claims.

As OIG and DOJ expand their fraud and abuse enforcement efforts, and new laws put health care professionals and entities under closer regulatory scrutiny, the effective review of compliance programs that address key risk areas and foster a culture of compliance is essential for health care businesses and professionals.

Compliance Takeaways

- Incorporate OIG's Provider Compliance Training materials as part of this year's annual compliance effectiveness review.
- Ask the OIG's transparency, accountability, and quality questions to prepare for health reform and heightened scrutiny of health care providers and suppliers.
- Review financial arrangements and track payment and services rendered to limit risk of Anti-kickback and Stark issues.
- Know who works for you by screening for exclusion and performing proper credentialing checks.

[4] . HHS OIG Voluntary Self-Disclosure Protocol is available online at http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf (last visited June 1, 2011).

[5] . HEAT Provider Compliance Training Presentation Materials, ''Operating an Effective Compliance Program,'' are available online at http://oig.hhs.gov/compliance/provider-compliance-training/index.asp (last visited June 1, 2011).