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AntiKickback; Fraud and Abuse – OIG Supplemental Compliance Program Guidance for Hospitals: Lessons for Hospice

Earlier this year, the OIG issued Supplemental Compliance Program Guidance for Hospitals (Supplemental Guidance) which includes new recommendations for compliance and a more thorough discussion of risk areas. Citing changes in hospital practices, lessons learned since the initial Program Guidance was issued in 1998, changes in payment and regulatory oversight as well as the priorities of the OIG in enforcement, the OIG sets forth a much more detailed guidance, which is useful not only for hospitals, but for their contracting partners. The Supplemental Guidance is an important reminder of the importance of a Corporate Compliance Plan and sheds tremendous light on the OIG's current enforcement efforts and priorities. Hospices are encouraged to read the report.

The Supplemental Guidance is important to hospices in two ways: First it describes certain relationships that a hospice might enter into with a hospital that could present a risk area. Second, it provides an important opportunity to understand current OIG thinking with regard to fraud and abuse in ways that may translate from hospitals to hospices. For example, the Supplemental Guidance enumerates a number of specific risk areas with regard to the submission of claims. Among these include "submitting claims for medically unnecessary services by failing to follow that FI's local policies." The Supplemental Guidance references local medical review policies (LMRPs) now known as local coverage determinations (LCDs), and states that "In addition to relying on a physician's sound clinical judgment with respect to the appropriateness of a proposed course of treatment, hospitals should regularly review and become familiar with their individual FI's LMRPs and LCDs. LMRPs and LCDs should be incorporated into a hospital's regular coding and billing operations."

The obvious parallel in hospice is that eligibility on admissions and recertifications should consider the RHHI's LCDs. While the LCDs are intended to be guidelines, and do not have the force of law, hospice IDGs should be very familiar with the LCDs and precise in their documentation of eligibility. The Supplemental Guidance also specifically addresses admissions and discharges as a risk area within the hospital setting. Parallels may be drawn in this area as well.

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With regard to the referral statutes, the Supplemental Guidance specifically references the physician self-referral law (the "Stark" law) and the federal anti-kickback statute.

The Stark law does not apply to the Medicare Hospice Benefit. However, as more hospices begin to provide "non-hospice" palliative care, the Stark issue must be squarely addressed. The statute prohibits claims for "designated health services" if referrals for such services come from a physician with whom the other provider has a prohibited financial relationship. Designated health services include clinical laboratory services, radiology, durable medical equipment, home health and other categories of service. Hospices embarking on unbundled non-hospice services should have their legal counsel carefully review their compliance with the Stark law.

Even if Stark is not an issue, the Supplemental Guidance is a reminder that anti-kickback prohibitions will be strictly enforced. The Guidance, while stressing that the anti-kickback statute is a matter of the party's intent, stresses that there are two useful inquiries. The first is whether the hospital has a relationship with an entity that could generate federal health care program business for the hospital and gives as examples "physicians and other health care professionals, ambulance companies, clinics, *hospices*, home health agencies, nursing facilities and other hospitals." (emphasis supplied) The second inquiry, if such a relationship is identified, is whether even one single purpose of the relationship is to induce a referral. The Supplemental Guidance makes it clear that "Neither a legitimate business purpose for the arrangement, nor a fair market value payment, will legitimize a payment if there is also an illegal purpose (*i.e.*, inducing federal health care program business). The Supplemental Guidance goes on to provide additional "aggravating considerations" that could be used to identify the arrangements at greatest risk of prosecution, and suggests that hospitals ask the following questions:

- *Does the arrangement or practice have a potential to interfere with, or skew, clinical decision-making?*
- Does the arrangement or practice have a potential to increase costs to federal health care programs, beneficiaries, or enrollees?
- *Does the arrangement or practice have a potential to increase the risk of over-utilization or inappropriate utilization?*
- *Does the arrangement or practice raise patient safety or quality of care concerns?*

The Supplemental Guidance goes on to point out that physicians are the key

source of referrals for hospitals and much of the discussion regarding risk areas focuses on this relationship. The Guidance states however that ". . . hospitals also receive referrals from other health care professionals, including physician assistants and nurse practitioners and from other providers and suppliers (such as ambulance companies, clinics, *hospices*, home health agencies, nursing facilities, and other hospitals." (emphasis supplied) The Guidance states: "Therefore in addition to reviewing their relationships with physicians, hospitals should also review their relationships with non-physician referral sources to ensure that the relationships do not violate the anti-kickback statute."

The Supplemental Guidance is very instructive with regard to medical director agreements and other physician contracts. The Guidance states: "In particular, hospitals should review their physician compensation arrangements and carefully assess the risk of fraud and abuse using the following factors, among others:

- *Are the items and services obtained from a physician legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose of the hospital (apart from obtaining referrals)? Assuming that the hospital needs the items and services, does the hospital have multiple arrangements with different physicians, so that in the aggregate the items or services provided by all physicians exceed the hospital's actual needs (apart from generating business)?*
- *Does the compensation represent fair market value in an arm's-length transaction for the items and services? Could the hospital obtain the services from a non-referral source at a cheaper rate or under more favorable terms? Does the remuneration take into or volume of any past or future referrals or other business generated between the parties? Is the compensation tied, directly or indirectly, to Federal health care program reimbursement?*
- *Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented? If fair market value is based on comparables, the hospital should ensure that the market rate for the comparable services is not distorted (e.g., the market for ancillary services may be distorted if all providers of the service are controlled by physicians).*
- *Is the compensation commensurate with the fair market value of a physician with the skill level and experience reasonably necessary to perform the contracted services?*
- *Were the physicians selected to participate in the arrangement in whole or in part because of their past or anticipated referrals?*
- *Is the arrangement properly and fully documented in writing? Are the physicians documenting the services they provide? Is the hospital monitoring the services?*

While it must be underscored that this Supplemental Guidance is for hospitals, not hospices, there is much useful information regarding the OIG's current enforcement priorities. Hospices are advised to do the following:

1. Periodically revisit the hospice corporate compliance plan. Is it up-to-date? Is it being followed?
2. Review medical director and other hospice physician contracts. Are they safe from and anti-kickback standpoint? Is Stark a consideration?
3. Review other provider contracts (hospital, nursing home, home health, etc.). Are they safe from an anti-kickback standpoint?
4. Review admission and discharge procedures. Are admissions and recertifications being handled appropriately? Is the hospice documenting appropriately?
5. Consider corporate compliance an important part of providing quality care to all hospice patients. Align the hospice's corporate compliance plan with best hospice practice.