DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Notice of this meeting is given under Office of Inspector General (OIG), HHS.

Dated: February 13, 1998.]

William K. Hubbard,
Associate Commissioner for Policy Coordination.

[FR Doc. 98-4374 Filed 2-20-98; 8.45 am]
BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Publication of the OIG Compliance Program Guidance for Hospitals

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This Federal Register notice sets forth the recently issued compliance program guidance for hospitals developed by the Office of Inspector General (OIG) in cooperation with, and with input from, several provider groups and industry representatives. Many providers and provider organizations have expressed an interest in better protecting their operations from fraud and abuse through the adoption of voluntary compliance programs. The first compliance guidance, addressing clinical laboratories, was prepared by the OIG and published in the Federal Register on March 3, 1997. We believe the development of this second program guidance, for hospitals, will continue as a positive step towards promoting a higher level of ethical and lawful conduct throughout the health care industry.

FOR FURTHER INFORMATION CONTACT: Stephen Davis, Office of Counsel to the Inspector General, (202) 619-0070.

SUPPLEMENTARY INFORMATION: The creation of compliance program guidances has become a major initiative of the OIG in its efforts to engage the private health care community in combating fraud and abuse. In developing these compliance guidances, the OIG has agreed to work closely with the Health Care Financing Administration, the Department of Justice and various sectors of the health care industry. The first of these compliance guidances focused on clinical laboratories, and was intended to provide clear guidance to those segments of the health care industry that were interested in reducing fraud and abuse within their organizations. The compliance guidance was reprinted in an OIG Federal Register notice published on March 3, 1997 (62 FR 9435). This second compliance program guidance developed by the OIG continues to build upon the basic elements contained in our initial compliance guidance, and encompasses principles that are applicable to hospitals as well as a wider variety of organizations that provide health care services to beneficiaries of Medicare, Medicaid and all other Federal health care programs.

Like the previously-issued compliance program guidance for clinical laboratories and future compliance program guidelines, adoption of the hospital compliance program guidance set forth below will be voluntary. Future compliance program guidances to be developed will be similarly structured and based on substantive policy recommendations, the elements of the Federal Sentencing Guidelines, and applicable statutes, regulations and Federal health care program requirements.

A reprint of the OIG compliance program guidance follows.

Compliance Program Guidance for Hospitals

I. Introduction

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) continues in its efforts to promote voluntarily developed and implemented compliance programs for the health care industry. The following compliance program guidance is intended to assist hospitals and their agents and subproviders (referred to collectively in this document as "hospitals") in develop effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State and private health plans. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse and waste in these health care plans while at the same time furthering the fundamental mission of
all hospitals, which is to provide quality care to patients. Within this document, the OIG intends to provide first, its general views on the value and fundamental principles of hospital compliance programs, and, second, specific elements that each hospital should consider when developing and implementing an effective compliance program. While this document presents basic procedural and structural guidance for designing a compliance program, it is not in itself a compliance program. Rather, it is a set of guidelines for a hospital interested in implementing a compliance program to consider. The recommendations and guidelines provided in this document must be considered depending upon their applicability to each particular hospital.

Fundamentally, compliance efforts are designed to establish a culture within a hospital that promotes prevention, detection and resolution of instances of conduct that do not conform to Federal and State law, and Federal, State and private payor health care program requirements, as well as the hospital’s ethical and business policies. In practice, the compliance program should effectively articulate and demonstrate the organization’s commitment to the compliance process. The existence of benchmarks that demonstrate implementation and achievements are essential to any effective compliance program. Eventually, a compliance program should become an integral part of the fabric of routine hospital operations.

Specifically, compliance programs guide a hospital’s governing body (e.g., Boards of Directors or Trustees), Chief Executive Officer (CEO), managers, other employees and physicians and other health care professionals in the efficient management and operation of a hospital. They are especially critical as an internal control in the reimbursement and payment areas, where claims and billing operations are often the source of fraud and abuse and, therefore, historically have been the focus of government regulation, scrutiny and sanctions.

It is incumbent upon a hospital’s corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct. Indeed, many hospitals and hospital organizations have adopted mission statements articulating their commitment to high ethical standards. A formal compliance program, as an additional element in this process, offers a hospital a further concrete method that may improve quality of care and reduce waste. Compliance programs also provide a central coordinating mechanism for furnishing and disseminating information and guidance on applicable Federal and State statutes, regulations and other requirements.

Adopting and implementing an effective compliance program requires a substantial commitment of time, energy and resources by senior management and the hospital’s governing body. Programs hastily constructed and implemented without appropriate ongoing monitoring will likely be ineffective and could result in greater harm or liability to the hospital than no program at all. While it may require significant additional resources or reallocation of existing resources to implement an effective compliance program, the OIG believes that the long term benefits of implementing the program outweigh the costs.

A. Benefits of a Compliance Program

In addition to fulfilling its legal duty to ensure that it is not submitting false or inaccurate claims to government and private payors, a hospital may gain numerous additional benefits by implementing an effective compliance program. Such programs make good business sense in that they help a hospital fulfill its fundamental caregiving mission to patients and the community, and assist hospitals in identifying weaknesses in internal systems and management.

Other important potential benefits include the ability to:

• Concretely demonstrate to employees and the community at large the hospital’s strong commitment to honest and responsible provider and corporate conduct;

• Provide a more accurate view of employee and contractor behavior relating to fraud and abuse;

• Identify and prevent criminal and unethical conduct;

• Tailor a compliance program to a hospital’s specific needs;

• Improve the quality of patient care;

• Create a centralized source for distributing information on health care statutes, regulations and other program guidelines related to fraud and abuse and related issues;

• Develop a methodology that encourages employees to report potential problems;

• Develop procedures that allow the prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other health care professionals and consultants;

• Initiate immediate and appropriate corrective action; and

• Through early detection and reporting, minimize the loss to the Government from false claims, and thereby reduce the hospital’s exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion.

Overall, the OIG believes that an effective compliance program is a sound investment on the part of a hospital.

The OIG recognizes that the implementation of a compliance program may not entirely eliminate fraud, abuse and waste from the hospital system. However, a sincere effort by hospitals to comply with applicable Federal and State standards, as well as the requirements of private health care programs, through the establishment of an effective compliance program, significantly reduces the risk of unlawful or improper conduct.

B. Application of Compliance Program Guidance

There is no single “best” hospital compliance program, given the diversity within the industry. The OIG understands the variances and complexities within the hospital industry and is sensitive to the differences among large urban medical centers, community hospitals, small, rural hospitals, specialty hospitals, and other types of hospital organizations and systems. However, elements of this guidance can be used by all hospitals, regardless of size, location or corporate structure, to establish an effective compliance program. We recognize that some hospitals may not be able to adopt certain elements to the same comprehensive degree that others with more extensive resources may achieve. This guidance represents the OIG’s suggestions on how a hospital can best establish internal controls and monitoring to correct and prevent fraudulent activities. By no means should the contents of this guidance be viewed as an exclusive discussion of the

1 Indeed, recent case law suggests that the failure of a corporate Director to attempt in good faith to institute a compliance program in certain situations may be a breach of a Director’s fiduciary obligations. See, e.g., In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Ct. Chanc. Del. 1996).

2 The OIG, for example, will consider the existence of an effective compliance program that predated any Governmental investigation when addressing the appropriateness of administrative penalties. Further, the False Claims Act, 31 U.S.C. 3729–3733, provides that a person who has violated the Act, but who voluntarily discloses the violation to the Government, in certain circumstances will be subject to not less than double, as opposed to treble, damages. See 31 U.S.C. 3729(a).
advisable elements of a compliance program.

The OIG believes that input and support by representatives of the major hospital trade associations is critical to the development and success of this compliance program guidance. Therefore, in drafting this guidance, the OIG received and considered input from various hospital and medical associations, as well as professional practice organizations. Further, we took into consideration previous OIG publications, such as Special Fraud Alerts and Management Advisory Reports, the recent findings and recommendations in reports issued by OIG’s Office of Audit Services and Office of Evaluation and Inspections, as well as the experience of past and recent fraud investigations related to hospitals conducted by OIG’s Office of Investigations and the Department of Justice.

As appropriate, this guidance may be modified and expanded as more information and knowledge is obtained by the OIG, and as changes in the law, and in the rules, policies and procedures of the Federal, State and private health plans occur. The OIG understands that hospitals will need adequate time to react to these modifications and expansions to make any necessary changes to their voluntary compliance programs. We recognize that hospitals are already accountable for complying with an extensive set of statutory and other legal requirements, far more specific and complex than what we have referenced in this document. We also recognize that the development and implementation of compliance programs in hospitals often raise sensitive and complex legal and managerial issues. However, the OIG wishes to offer what it believes is critical guidance for providers who are sincerely attempting to comply with the wishes to offer what it believes is

sincerely attempting to comply with the relevant health care statutes and regulations.

II. Compliance Program Elements

The elements proposed by these guidelines are similar to those of the clinical laboratory model compliance program published by the OIG in February 1997 and our corporate integrity agreements. The elements represent a guide—a process that can be used by hospitals, large or small, urban or rural, for-profit or not for-profit. Moreover, the elements can be incorporated into the managerial structure of multi-hospital and integrated delivery systems. As we stated in our clinical laboratory plan, these suggested guidelines can be tailored to fit the needs and financial realities of a particular hospital. The OIG is cognizant that with regard to compliance programs, one model is not suitable to every hospital. Nonetheless, the OIG believes that every hospital, regardless of size or structure, can benefit from the principles espoused in this guidance.

The OIG believes that every effective compliance program must begin with a formal commitment by the hospital’s governing body to include all of the applicable elements listed below. These elements are based on the seven steps of the Federal Sentencing Guidelines. Further, we believe that every hospital can implement most of our recommended elements that expand upon the seven steps of the Federal Sentencing Guidelines. We recognize that full implementation of all elements may not be immediately feasible for all hospitals. However, as a first step, a good faith and meaningful commitment on the part of the hospital administration, especially the governing body and the CEO, will substantially contribute to a program’s successful implementation.

At a minimum, comprehensive compliance programs should include the following seven elements:

1. The development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital’s commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;

2. The designation of a chief compliance officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;

3. The development and implementation of regular, effective education and training programs for all affected employees;

4. The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;

5. The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements;

6. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area; and

7. The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

A. Written Polices and Procedures

Every compliance program should require the development and distribution of written compliance policies that identify specific areas of risk to the hospital. These policies should be developed under the direction and supervision of the chief compliance officer and compliance committee, and, at a minimum, should be provided to all individuals who are affected by the particular policy at issue, including the hospital’s agents and independent contractors.

1. Standards of Conduct. Hospitals should develop standards of conduct for all affected employees that include a clearly delineated commitment to compliance by the hospital’s senior management and its divisions.

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Footnotes:

3 Nothing stated herein should be substituted for, or used in lieu of, competent legal advice from counsel.


5 Corporate integrity agreements are executed as part of a civil settlement between the health care provider and the Government to resolve a case arising under the False Claims Act (FCA), including the qui tam provisions of the FCA, based on allegations of health care fraud or abuse. These OIG-imposed programs are in effect for a period of three to five years and require many of the elements included in this compliance guidance.

6 See United States Sentencing Commission Guidelines, Guidelines Manual, §A1.2, comment. (n.3(c)); Current HCFA reimbursement principles provide that certain of the costs associated with the creation of a voluntarily established compliance program may be allowable costs on certain types of hospitals’ cost reports. These allowable costs, of course, must at a minimum be reasonable and related to patient care. See generally 42 U.S.C. §1395(v)(i)(A) (definition of reasonable cost); 42 CFR §413.6(a) and (b)(1) (costs related to patient care). In contrast, however, costs specifically associated with the implementation of a corporate integrity agreement in response to a Government investigation arising in a civil or criminal case, and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;

7 The OIG strongly encourages high-level involvement by the hospital’s governing body, chief executive officer, chief operating officer, general counsel, and chief financial officer, as well as other medical personnel, as appropriate, in the development of standards of conduct. Such
The OIG periodically issues Special FraudAlerts setting forth activities believed to raise legal and enforcement issues. Hospital compliance programs are critical to the legal staff, chief compliance officer, or other appropriate personnel, carefully consider any and all Special Fraud Alerts issued by the OIG that relate to hospitals. Moreover, the compliance programs should address the ramifications of failing to cease and correct any conduct criticized in such a Special Fraud Alert, if applicable to hospitals, or to take reasonable action to prevent such conduct from reoccurring in the future. If appropriate, a hospital should take the steps described in Section G regarding investigations, reporting and correction of identified problems.

The OIG's work plan is currently available on the Internet at http://www.dhhs.gov/progorg/oig.

Billing for services not actually rendered involves submitting a claim that represents that the provider performed a service all or part of which was simply not performed. This form of billing fraud occurs in many health care entities, including hospitals and nursing homes, and represents a significant part of the OIG's investigative caseload.

A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition. See 42 U.S.C. 1395y(a)(1)(A) (“no payment may be made under part A or part B for any expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member”). On every HCFA claim form, a physician must certify that the services were medically necessary for the health of the beneficiary.

“Upcoding” reflects the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient. Upcoding has been a major focus of the OIG’s enforcement efforts. In fact, the Health Insurance Portability and Accountability Act of 1996 added another civil monetary penalty to the OIG’s sanction authorities for upcoding violations. See 42 U.S.C. 1320a-7a(a)(1)(A).

Like upcoding, “DRG creep” is the practice of billing using a Diagnosis Related Group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient. Hospitals that submit claims for non-physician outpatient services that were already included in the hospital’s inpatient payment under the Prospective Payment System (PPS) are in effect submitting duplicate claims.

Duplicate billing occurs when the hospital submits more than one claim for the same service or the bill is submitted to more than one payer at the same time. Although duplicate billing can occur due to simple error, systematic or repeated double billing may be viewed as a false claim, particularly if any overpayment is not promptly refunded.

As another example of health care fraud, the submission of false costs reports is usually limited to certain Part A providers, such as hospitals, skilled nursing facilities and home health agencies, which are reimbursed in part on the basis of their self-reported operating costs. An OIG audit report on the misuse of fringe benefits and general and administrative costs identified millions of dollars in unlawful costs that resulted from providers’ lack of internal controls over costs included in their Medicare cost reports. In addition, the OIG is aware of practices in which hospitals improperly shift certain costs to cost centers that are below their reimbursement cap and shift non-Medicare related costs to Medicare cost centers.

Under the Medicare regulations, when a prospective payment system (PPS) hospital transfers a patient to another PPS hospital, only the hospital to which the patient was transferred may charge the full DRG; the transferring hospital should charge Medicare only a per diem amount.

This area of concern is particularly important for hospital discharge planners referring patients to home health agencies, DME suppliers or long term care and rehabilitation providers.

Excessive payment for medical directorships, free or below market rents or fees for administrative services, interest-free loans and excessive payment for intangible assets in physician practice acquisitions are examples of arrangements that may run afoul of the anti-kickback statute. See 42 U.S.C. 1320a-7(b) and 49 CFR 4990.12(12/9/94).

Equally troubling to the OIG is the proliferation of business arrangements that may violate the anti-kickback statute. Such arrangements are generally established between those providing business, such as physicians, and those providing items or services for which a Federal health care program pays. Sometimes established as “joint ventures,” these arrangements may take a variety of forms. The OIG currently has a number of investigations and audits underway that focus on such areas of concern.

Another area of concern with respect to the anti-kickback statute is hospital financial arrangements with hospital-based physicians that compensate physicians for less than the fair market value of services they provide to hospitals or require physicians to pay more than market value for services provided by the hospital. See OIG Management Advisory Report: “Financial Arrangements Between Hospitals and Hospital-Based Physicians.” OEl-09-89-0030, October 1991. Examples of such arrangements that may violate the anti-kickback statute are token or no payment for Part A supervision and management services, requirements to donate equipment to hospitals; and excessive charges for billing services.

The patient anti-dumping statute, 42 U.S.C. 1395ddd, requires that all Medicare participating hospitals with an emergency department: (1) Provide for an appropriate medical screening examination to determine whether or not an individual requesting such examination has an emergency medical condition; and (2) if the person...
Additional risk areas should be assessed as well by hospitals and incorporated into the written policies and procedures and training elements developed as part of their compliance programs.

3. Claim Development and Submission Process. A number of the risk areas identified above, pertaining to the claim development and submission process, have been the subject of administrative proceedings, as well as investigations and proceedings under the civil False Claims Act and criminal statutes. Settlement of these cases often has required the defendants to execute corporate integrity agreements, in addition to paying significant civil damages and/or criminal fines and penalties. These corporate integrity agreements have provided the OIG with a mechanism to advise hospitals concerning what it feels are acceptable practices to ensure compliance with applicable Federal and State statutes, regulations, and program requirements. The following recommendations include a number of provisions from various corporate integrity agreements. While these recommendations include examples of effective policies, each hospital should develop its own specific policies tailored to fit its individual needs.

With respect to reimbursement claims, a hospital’s written policies and procedures should reflect and reinforce current Federal and State statutes and regulations regarding the submission of claims and Medicare cost reports. The policies must create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical staff. Policies and procedures should:

- Provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed;
- Emphasize that claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained and available for audit and review. The documentation, which may include patient records, should record the length of time spent in conducting the activity leading to the record entry, and the identity of the individual providing the service. The hospital should consult with its medical staff to establish other appropriate documentation guidelines;
- State that, consistent with appropriate guidance from medical staff, physician and hospital records and medical notes used as a basis for a claim submission should be appropriately organized in a legible form so they can be audited and reviewed;
- Indicate that the diagnosis and procedures reported on the reimbursement claim should be based on the medical record and other documentation, and that the documentation necessary for accurate code assignment should be available to coding staff; and
- Provide that the compensation for billing department coders and billing consultants should not provide any financial incentive to improperly upcode claims. The written policies and procedures concerning proper coding should reflect the current reimbursement principles set forth in applicable regulations and should be developed in tandem with private payers and organizational standards. Particular attention should be paid to issues of medical necessity, appropriate diagnosis codes, DRG coding, individual Medicare Part B claims (including evaluation and management coding) and the use of patient discharge codes;

a. Outpatient services rendered in connection with an inpatient stay. Hospitals should implement measures designed to demonstrate their good faith efforts to comply with the Medicare billing rules for outpatient services rendered in connection with an inpatient stay. Although not a guard against intentional wrongdoing, the adoption of the following measures are advisable:

27 The official coding guidelines are promulgated by HCFA, the National Center for Health Statistics, the American Medical Association and the American Health Information Management Association. See International Classification of Diseases, 9th Revision, Clinical Modification (ICD9-CM); 1998 Health Care Financing Administration Common Procedure Coding System (HCPCS); and Physicians’ Current Procedural Terminology (CPT).

28 The failure of hospital staff to: (i) document items and services rendered; and (ii) properly submit them for reimbursement is a major area of potential fraud and abuse in Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives aimed at reducing potential and actual fraud, abuse, and waste. Recent OIG audit reports, which have focused on issues such as hospital patient transfers incorrectly paid as inpatient services, have identified significant overpayments and improper billing.

29 The OIG’s February 1997 Model Compliance Plan for Clinical Laboratories provides more specific and detailed information than is contained in this section, and hospitals that have clinical laboratories should extract the relevant guidance from both documents.
physician and performed by the hospital laboratory;

- The coding staff: (1) Only submit diagnostic information obtained from qualified personnel; and (2) contact the appropriate personnel to obtain diagnostic information in the event that the individual who ordered the test has failed to provide such information; and

- Where diagnostic information is obtained from a physician or the physician’s staff after receipt of the specimen and request for services, the receipt of such information is documented and maintained.

c. Physicians at teaching hospitals. Hospitals should ensure the following with respect to all claims submitted on behalf of teaching physicians:

- Only services actually provided may be billed;

- Every physician who provides or supervises the provision of services to a patient should be responsible for the correct documentation of the services that were rendered;

- The appropriate documentation must be placed in the patient record and signed by the physician who provided or supervised the provision of services to the patient;

- Every physician is responsible for assuring that in cases where that physician provides evaluation and management (E&M) services, a patient’s medical record includes appropriate documentation of the applicable key components of the E&M service provided or supervised by the physician (e.g., patient history, physician examination, and medical decision making), as well as documentation to adequately reflect the procedure or portion of the service performed by the physician; and

- Every physician should document his or her presence during the key portion of any service or procedure performed by the physician.

d. Cost reports. With regard to cost report issues, the written policies should include procedures that seek to ensure full compliance with applicable statutes, regulations and program requirements and applicable payer plans. Among other things, the hospital’s procedures should ensure that:

- Costs are not claimed unless based on appropriate and accurate documentation;

- All allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data;

- Unallowable costs are not claimed for reimbursement;

- Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;

- Costs are properly classified;

- Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or clearly identified as protested amounts on the cost report;

- All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;

- Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;

- The hospital’s procedures for reporting of bad debts on the cost report are in accordance with Federal statutes, regulations, guidelines and policies;

- Allocations from a hospital chain’s home office cost statement to individual hospital cost reports are accurately made and supportable by verifiable and auditable data; and

- Procedures are in place and documented for notifying promptly the Medicare fiscal intermediary (or any other applicable payor, e.g., TRICARE (formerly CHAMPUS) and Medicaid) of errors discovered after the submission of the hospital cost report, and where applicable, after the submission of a hospital chain’s home office cost statement.

With regard to bad debts claimed on the Medicare cost report, see also section six, below, on Bad Debts.

4. Medical Necessity—Reasonable and Necessary Services. A hospital’s compliance program should provide that claims should only be submitted for services that the hospital has reason to believe are medically necessary and that were ordered by a physician or other appropriately licensed individual.

As a preliminary matter, the OIG recognizes that licensed health care professionals must be able to order any services that are appropriate for the treatment of their patients. However, Medicare does not require government and private health care plans will only pay for those services that meet appropriate medical necessity standards (in the case of Medicare, i.e., “reasonable and necessary” services). Providers may not bill for services that do not meet the applicable standards. The hospital is in a unique position to deliver this information to the health care professionals on its staff. Upon request, a hospital should be able to provide documentation, such as patients’ medical records and physicians’ orders, to support the medical necessity of a service that the hospital has provided. The compliance officer should ensure that a clear, comprehensive summary of the “medical necessity” definitions and rules of the various government and private plans is prepared and disseminated appropriately.

5. Anti-Kickback and Self-Referral Concerns. The hospital should have policies and procedures in place with respect to compliance with Federal and State anti-kickback statutes, as well as the Stark physician self-referral law. Such policies should provide that:

- All of the hospital’s contracts and arrangements with referral sources comply with all applicable statutes and regulations;

- The hospital does not submit or cause to be submitted to the Federal health care programs claims for patients who were referred to the hospital pursuant to contracts and financial arrangements that were designed to induce such referrals in violation of the anti-kickback statute. Stark physician self-referral law or similar Federal or State statute or regulation; and

- The hospital does not enter into financial arrangements with hospital-based physicians that are designed to provide inappropriate remuneration to the hospital in return for the physician’s ability to provide services to Federal health care program beneficiaries at that hospital.

Further, the policies and procedures should reference the OIG’s safe harbor regulations, clarifying those payment practices that would be immune from prosecution under the anti-kickback statute. See 42 CFR 1001.952.

6. Bad Debts. A hospital should develop a mechanism to review, at least annually: (1) whether it is properly reporting bad debts to Medicare; and (2) all Medicare bad debt expenses claimed, to ensure that the hospital’s procedures are in accordance with applicable...

31 Towards this end, the hospital’s in-house counsel or compliance officer should, inter alia, obtain copies of all OIG regulations, special fraud alerts and advisory opinions concerning the anti-kickback statute, Civil Monetary Penalties Law (CMPL) and Stark physician self-referral law (the fraud alerts and anti-kickback or CMPL advisory opinions are published on HHS OIG’s home page on the Internet), and ensure that the hospital’s policies reflect the guidance provided by the OIG.

32 See fn. 25, supra.

33 E.g., assigning in-house counsel or contracting with an independent professional organization, such as an accounting, law or consulting firm.

30 For Medicare reimbursement purposes, a physician is defined as: (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or of dental medicine; (3) a podiatrist; (4) an optometrist; and (5) a chiropractor, all of whom must be appropriately licensed by the state. 42 U.S.C. 1395x(r).
Federal and State statutes, regulations, guidelines and policies. In addition, such a review should ensure that the hospital has appropriate and reasonable mechanisms in place regarding beneficiary deductible or copayment collection efforts and has not claimed as bad debts any routinely waived Medicare copayments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. Further, the hospital may consult with the appropriate fiscal intermediary as to bad debt reporting requirements, if questions arise.

7. Credit Balances. The hospital should institute procedures to provide for the timely and accurate reporting of Medicare and other Federal health care program credit balances. For example, a hospital may redesignate segments of its information system to allow for the segregation of patient accounts reflecting credit balances. The hospital could remove these accounts from the active accounts and place them in a holding account pending the processing of a reimbursement claim to the appropriate program. A hospital's information system should have the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.

In addition, a hospital should designate at least one person (e.g., in the Patient Accounts Department or reasonable equivalent thereof) as having the responsibility for the tracking, recording and reporting of credit balances. Further, a comptroller or an accountant in the hospital's Accounting Department (or reasonable equivalent thereof) may review reports of credit balances and reimbursements or adjustments on a monthly basis as an additional safeguard.

8. Retention of Records. Hospital compliance programs should provide for the implementation of a records system. This system should establish policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents. The two types of documents developed under this system should include: (1) all records and documentation, e.g., clinical and medical records and claims documentation, required either by Federal or State law for participation in Federal health care programs (e.g., Medicare's conditions of participation requirement that hospital records regarding Medicare claims be retained for a minimum of five years, see 42 CFR 482.24(b)(1) and HCFA Hospital Manual section 413(C)(32–91)); and (2) all records necessary to protect the integrity of the hospital's compliance process and confirm the effectiveness of the program, e.g., documentation that employees were adequately trained; reports from the hospital's hotline, including the nature and results of any investigation that was conducted; modifications to the compliance program; self-disclosure; and the results of the hospital's auditing and monitoring efforts.

9. Compliance as an Element of a Performance Plan. Compliance programs should require that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers and supervisors. They, along with other employees, should be periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims and cost report development and submission processes should:

• Discuss with all supervised employees the compliance policies and legal requirements applicable to their function;
• Inform all supervised personnel that strict compliance with these policies and requirements is a condition of employment; and
• Disclose to all supervised personnel that the hospital will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

In addition to making performance of these duties an element in evaluations, the compliance officer or hospital management should include in the hospital's compliance program a policy that managers and supervisors will be sanctioned for failure to instruct adequately their subordinates or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any problems or violations and given the hospital the opportunity to correct them earlier.

B. Designation of a Compliance Officer and a Compliance Committee

1. Compliance Officer. Every hospital should designate a compliance officer to serve as the focal point for compliance activities. This responsibility may be the individual's sole duty or added to other management responsibilities, depending upon the size and resources of the hospital and the complexity of the task.

34 The creation and retention of such documents and reports may raise a variety of legal issues, such as patient privacy and confidentiality. These issues are best discussed with legal counsel.

Designating a compliance officer with the appropriate authority is critical to the success of the program, necessitating the appointment of a high-level official in the hospital with direct access to the hospital’s governing body and the CEO. The officer should have sufficient funding and staff to perform his or her responsibilities fully. Coordination and communication are the key functions of the compliance officer with regard to planning, implementing, and monitoring the compliance program.

The compliance officer's primary responsibilities should include:

• Overseeing and monitoring the implementation of the compliance program;

• Reporting on a regular basis to the hospital's governing body, CEO and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the hospital's efficiency and quality of services, and to reduce the hospital's vulnerability to fraud, abuse and waste;

• Periodically revising the program in light of changes in the needs of the organization, and in the law and policies and procedures of government and private payor health plans;

• Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State standards;

• Ensuring that independent contractors and agents who furnish medical services to the hospital are aware of the requirements of the hospital's compliance program with respect to coding, billing, and marketing, among other things;

• Coordinating personnel issues with the hospital's Human Resources office.

35 The OIG believes that there is some risk to establishing an independent compliance function if that function is subordinate to the hospital's general counsel, or comptroller or similar hospital financial officer. Free standing compliance functions help to ensure independent and objective legal reviews and financial analyses of the institution's compliance activities. By separating the compliance function from the key management positions of general counsel or chief hospital financial officer (where the size and structure of the hospital make this a feasible option), a system of checks and balances is established to more effectively achieve the goals of the compliance program.

36 For multi-hospital organizations, the OIG encourages coordination with each hospital owned by the corporation or foundation through the use of a headquarter's compliance officer, communicating with parallel positions in each facility, or regional office, as appropriate.
program. The committee’s functions should include:

- Analyzing the organization’s industry environment, the legal requirements with which it must comply, and specific risk areas;
- Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program;
- Working with appropriate hospital departments to develop standards of conduct and policies and procedures to promote compliance with the institution’s program;
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the organization’s standards, policies, and procedures as part of its daily operations;
- Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and
- Developing a system to solicit, evaluate, and respond to complaints and problems.

The committee may also address other functions as the compliance concept becomes part of the overall hospital operating structure and daily routine.

C. Conducting Effective Training and Education

The proper education and training of corporate officers, managers, employees, physicians, other health care professionals, and the continual retraining of current personnel at all levels, are significant elements of an effective compliance program. As part of their compliance programs, hospitals should require personnel to attend training sessions highlighting the organization’s standards, policies, and procedures as part of its daily operations, including appropriate training in the risk areas identified in section II.A.2, above, and specific training in the risk areas identified in section II.A.2, above, including specific training in the risk areas identified in section II.A.2, above, including appropriate training in the risk areas identified in section II.A.2, above.

These training programs should include sessions highlighting the organization’s compliance program, summarizing access to the Health Care Fraud and Abuse Advisory Report entitled “Financial Arrangements between Hospitals and Hospital-Based Physicians,” Special Fraud Alerts, audit and inspection reports, and advisory opinions, as well as the annual OIG report. A variety of teaching methods, as such as interactive training, training in several different languages, particularly where a hospital has a culturally diverse staff, should be implemented so that all affected employees are knowledgeable of the institution’s standards of conduct and procedures for alerting senior management to problems and concerns. Targeted training should be provided to corporate officers, managers, and other employees whose actions affect the accuracy of the claims submitted to the Government, such as employees involved in the coding, billing, cost reporting, and marketing processes.

Given the complexity and interdependent relationships of many departments, proper coordination and supervision of this process by the compliance officer is important. In addition to specific training in the risk areas identified in section II.A.2, above, primary training to appropriate corporate officers, managers, and other employees should include such topics as:

- Government and private payor reimbursement principles;
- General prohibitions on paying or receiving remuneration to induce referrals;
- Proper confirmation of diagnoses;
- Special prohibitions on paying or receiving remuneration to induce referrals;
- Proper confirmation of diagnoses;
• Submitting a claim for physician services when rendered by a non-
physician (i.e., the “incident to” rule and the physician physical presence
requirement);
• Signing a form for a physician without the physician’s authorization;
• Alterations to medical records;
• Prescribing medications and procedures without proper
authorization;
• Proper documentation of services rendered; and
• Duty to report misconduct.

Clarifying and emphasizing these areas of concern through training and
educational programs are particularly relevant to a hospital’s marketing and
financial personnel, in that the pressure to meet business goals may render these
employees vulnerable to engaging in prohibited practices.

The OIG suggests that all relevant
levels of personnel be made part of
various educational and training
programs of the hospital. Employees
should be required to have a minimum
number of educational hours per year,
as appropriate, as part of their
employment responsibilities. For
example, for certain employees involved
in the billing and coding functions,
periodic training in proper DRG coding
and documentation of medical records
should be required. In hospitals with high
employee turnover, periodic
training updates are critical.

The OIG recommends that attendance
and participation in training programs
be made a condition of continued
employment and that failure to comply
with training requirements should result
disciplinary action, including
possible termination, when such failure
is serious. A adherence to the provisions
of the compliance program, such as
training requirements, should be a factor
in the annual evaluation of each
employee. The hospital should retain
adequate records of its training of
employees, including attendance logs
and material distributed at training
sessions.

Finally, the OIG recommends that
hospital compliance programs address
the need for periodic professional
education courses that may be required
by statute and regulation for certain
hospital personnel.

D. Developing Effective Lines of
Communication

1. Access to the Compliance Officer.
An open line of communication
between the compliance officer and
hospital personnel is equally important
to the successful implementation of a
compliance program and the reduction
of any potential for fraud, abuse and
waste. Written confidentiality and non-
retaliation policies should be developed
and distributed to all employees to
encourage communication and the
reporting of incidents of potential
fraud. The compliance committee
should also develop several
independent reporting paths for an
employee to report fraud, waste or abuse
so that such reports cannot be diverted
by supervisors or other personnel.

The OIG encourages the establishment
of a procedure so that hospital
personnel may seek clarification
from the compliance officer or members
of the compliance committee in the event
of any confusion or question with regard
to a hospital policy or procedure.
Questions and responses should be
documented and dated and, if
appropriate, shared with other staff so
that standards, policies and procedures
can be updated and improved to reflect
any necessary changes or clarifications.
The compliance officer may want to
request employee input in developing
these communication and reporting
systems.

2. Hotlines and Other Forms of
Communication. The OIG encourages
the use of hotlines (including
anonymous hotlines), e-mails, written
memoranda, newsletters, and other
forms of information exchange to
maintain these open lines of
communication. If the hospital
establishes a hotline, the telephone
number should be made readily
available to all employees and
independent contractors, possibly
by conspicuously posting the telephone
number in common work areas.46

Employees should be permitted to
report matters on an anonymous basis.
Matters reported through the hotline or
other communication sources that
suggest substantial violations of
compliance policies, regulations or
statutes should be documented and
investigated promptly to determine their
veracity. A log should be maintained by
the compliance officer that records such
calls, including the nature of any
investigation and its results. Such
information should be included in
reports to the governing body, the CEO
and compliance committee. Further,
while the hospital should always strive
to maintain the confidentiality of an
employee’s identity, it should also
explicitly communicate that there may
be a point where the individual’s
identity may become known or may
have to be revealed in certain instances
when governmental authorities become
involved.

The OIG recognizes that assertions of
fraud and abuse by employees who may
have participated in illegal conduct or
committed other malfeasance raise
numerous complex legal and
management issues that should be
examined on a case-by-case basis. The
compliance officer should work closely
with legal counsel, who can provide
guidance regarding such issues.

E. Enforcing Standards Through Well-
Publicized Disciplinary Guidelines

1. Discipline Policy and Actions. An
effective compliance program should
include guidance regarding disciplinary
action for corporate officers, managers,
employees, physicians and other health
care professionals who have failed to
comply with the hospital’s standards of
code of conduct, policies and procedures,
or Federal and State laws, or those who
have otherwise engaged in wrongdoing,
which have the potential to impair the
hospital’s status as a reliable, honest
and trustworthy health care provider.

The OIG believes that the compliance
program should include a written policy
statement setting forth the degrees of
disciplinary actions that may be
imposed upon corporate officers,
managers, employees, physicians and
other health care professionals for
failing to comply with the hospital’s
standards and policies and applicable
laws and regulations. Intentional or
reckless noncompliance should subject
transgressors to significant sanctions.
Such sanctions could range from oral

42 Currently, the OIG is monitoring approximately
165 corporate integrity agreements that require
many of these training elements. The OIG usually
requires a minimum of one to three hours annually
for basic training in compliance areas. More is
required for speciality fields such as billing and
coding.

43 Accurate coding depends upon the quality and
completeness of the physician’s documentation.
Therefore, the OIG believes that active staff
physician participation in educational programs
focusing on coding and documentation should be
emphasized by the hospital.

44 In addition, where feasible, the OIG believes
that a hospital’s outside contractors, including
physician corporations, should be afforded the
opportunity to participate in, or develop their own,
compliance training and educational programs,
which complement the hospital’s standards of
conduct, compliance requirements, and other rules
and regulations.

45 The OIG believes that whistleblowers should be
protected against retaliation, a concept embodied
in the provisions of the False Claims Act. In many
cases, employees sue their employers under the
False Claims Act’s qui tam provisions out of
frustration because of the company’s failure to take
action when a questionable, fraudulent or abusive
situation was brought to the attention of senior
company officials.

46 Hospitals should also post in a prominent,
available area the HHS OIG Hotline telephone
number, 1-800-HHS-TIPS (447-8477), in addition
to any company hotline number that may be posted.
warnings to suspension, privilege revocation (subject to any applicable peer review procedures), termination or financial penalties, as appropriate. The written standards of conduct should elaborate on the procedures for handling disciplinary problems and those who will be responsible for taking appropriate action. Some disciplinary actions can be handled by department managers, while others may have to be resolved by a senior hospital administrator. Disciplinary action may be appropriate where a responsible employee's failure to detect a violation is attributable to his or her negligence or reckless conduct. Personnel should be advised by the hospital that disciplinary action will be taken on a fair and equitable basis. Managers and supervisors should be made aware that they have a responsibility to discipline employees in an appropriate and consistent manner.

It is vital to publish and disseminate the range of disciplinary standards for improper conduct and to educate officers and other hospital staff regarding these standards. The consequences of noncompliance should be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect. All levels of employees should be subject to the same disciplinary action for the commission of similar offenses. The commitment to compliance applies to all personnel levels within a hospital. The OIG believes that corporate officers, managers, supervisors, medical staff and other health care professionals should be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, laws, and procedures.

2. New Employee Policy. For all new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application. The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 U.S.C. 1320a-7(j), or exclusion action. Pursuant to the compliance program, hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in Federal health care programs (as defined in 42 U.S.C. 1320a-7(b)(6)). In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, the OIG recommends that such individuals should be removed from direct responsibility for or involvement in any Federal health care program. With regard to current employees or independent contractors, if resolution of the matter results in conviction, debarment or exclusion, the hospital should terminate its employment or other contract arrangement with the individual or contractor.

F. Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. The OIG believes that an effective program should incorporate thorough monitoring of its implementation and regular reporting to senior hospital or corporate officers. Compliance reports created by this ongoing monitoring, including reports of suspected noncompliance, should be maintained by the compliance officer and shared with the hospital’s senior management and the compliance committee.

Although many monitoring techniques are available, one effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in Federal and State health care statutes, regulations and Federal health care program requirements. The audits should focus on the hospital’s programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions. At a minimum, these audits should be designed to address the hospital’s compliance with laws governing kickback arrangements, the physician self-referral prohibition, CPT/HCPCS ICD-9 coding, claim development and submission, reimbursement, cost reporting and marketing. In addition, the audits and reviews should inquire into the hospital’s compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers, and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations, and law enforcement’s initiatives. See section II.A.2, supra. In addition, the hospital should focus on any areas of concern that have been identified by any entity, i.e., Federal, State, or internally, specific to the individual hospital.

Monitoring techniques may include sampling protocols that permit the compliance officer to identify and review variations from an established baseline. Significant variations from the baseline should trigger a reasonable inquiry to determine the cause of the deviation. If the inquiry determines that the deviation occurred for legitimate, explainable reasons, the compliance officer, hospital administrator or manager may wish to limit any corrective action or take no action. If it is determined that the deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, the hospital should take prompt steps to correct the problem. Any overpayments discovered as a result of such deviations should be returned promptly to the affected payor, with appropriate documentation and a thorough explanation of the reason for the refund.

Monitoring techniques may also include a review of any reserves the hospital has established for payments that it may owe to Medicare, Medicaid, TRICARE or other Federal health care programs. Any reserves discovered that include funds that should have been paid to Medicare or another government program should be paid promptly.

48 Likewise, hospital compliance programs should establish standards prohibiting the execution of contracts with companies that have been recently convicted of a criminal offense related to health care or that are listed by a Federal agency as debarred, excluded, or otherwise ineligible for participation in Federal health care programs.

49 Prospective employees who have been officially reinstated into the Medicare and Medicaid programs by the OIG may be considered for employment upon proof of such reinstatement.

50 Even when a hospital is owned by a larger corporate entity, the regular auditing and monitoring of the compliance activities of an individual hospital must be a key feature in any annual review. Appropriate reports on audit findings should be periodically provided and explained to a parent-organization’s senior staff and officers.

51 The OIG recommends that when a compliance program is established in a hospital, the compliance officer, with the assistance of department managers, should take a “snapshot” of their operations from a compliance perspective. This assessment can be undertaken by outside consultants, law or accounting firms, or internal staff, with authoritative knowledge of health care compliance requirements. This “snapshot,” often used as part of benchmarking analyses, becomes a baseline for the compliance officer and other managers to judge the hospital’s progress in reducing or eliminating potential areas of vulnerability. For example, it has been suggested that a baseline level include the frequency and percentile levels of various diagnosis codes and the increased billing of complications and co-morbidities.

52 In addition, when appropriate, as referenced in section G.2 reports of fraud or systemic problems should also be made to the appropriate governmental authority.
regardless of whether demand has been made for such payment.

An effective compliance program should also incorporate periodic (at least annual) reviews of whether the program's compliance elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs and disciplinary actions, among others. This process will verify actual conformance by all departments with the compliance program. Such reviews could support a determination that appropriate records have been created and maintained to document the implementation of an effective program. However, when monitoring discloses that deviations were not detected in a timely manner due to program deficiencies, appropriate modifications must be implemented.

Such evaluations, when developed with the support of management, can help ensure compliance with the hospital's policies and procedures.

As part of the review process, the compliance officer or reviewers should consider techniques such as:

- On-site visits;
- Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities;
- Questionnaires developed to solicit impressions of a broad cross-section of the hospital's employees and staff;
- Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports;
- Review of written materials and documentation prepared by the different divisions of a hospital; and
- Trend analysis, or longitudinal studies, that seek deviations, positive or negative, in specific areas over a given period.

The reviewers should:

- Be independent of physicians and line management;
- Have access to existing audit and health care resources, relevant personnel and all relevant areas of operation;
- Present written evaluative reports on compliance activities to the CEO, governing body and members of the compliance committee on a regular basis, but no less than annually; and
- Specifically identify areas where corrective actions are needed.

With these reports, hospital management can take whatever steps are necessary to correct past problems and prevent them from reoccurring. In certain cases, subsequent reviews or studies would be advisable to ensure that the recommended corrective actions have been implemented successfully.

The hospital should document its efforts to comply with applicable statutes, regulations and Federal health care program requirements. For example, when a hospital, in its efforts to comply with a particular statute, regulation or program requirement, requests advice from a government agency (including a Medicare fiscal intermediary or carrier) charged with administering a Federal health care program, the hospital should document and retain a record of the request and any written or oral response. This step is extremely important if the hospital intends to rely on that response to guide it in future decisions, actions or claim reimbursement requests or appeals.

Maintaining a log of oral inquiries between the hospital and third parties represents an additional basis for establishing documentation on which the organization may rely to demonstrate attempts at compliance. Records should be maintained demonstrating reasonable reliance and due diligence in developing procedures that implement such advice.

G. Responding to Detected Offenses and Developing Corrective Action Initiatives

1. Violations and Investigations.

Violations of a hospital's compliance program, failures to comply with applicable Federal or State law, and other types of misconduct threaten a hospital's status as a reliable, honest and trustworthy provider capable of participating in Federal health care programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the hospital. Consequently, upon receipt or reasonable indicators of suspected noncompliance, it is important that the chief compliance officer or other management officials initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Government, and the submission of any overpayments, if applicable.

Where potential fraud or False Claims Act liability is not involved, the OIG recognizes that HCFA regulations and contractor guidelines already include procedures for returning overpayments to the Government as they are discovered. However, even if the overpayment detection and return process is working and is being monitored by the hospital's auditor or coding divisions, the OIG still believes that the compliance officer needs to be made aware of these overpayments, violations or deviations and look for trends or patterns that may demonstrate a systemic problem.

Depending upon the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents. Some hospitals should consider engaging outside counsel, auditors, or health care experts to assist in an investigation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, the results of the investigation, e.g., any disciplinary action taken, and the corrective action implemented. While any action taken as the result of an investigation will necessarily vary depending upon the hospital and the situation, hospitals should strive for some consistency by utilizing sound practices and disciplinary protocols. Further, after a reasonable period, the compliance officer should review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

53 Advice from the hospital's in-house counsel or an outside law firm may be sought to determine the extent of the hospital's liability and to plan the appropriate course of action.

54 The OIG currently maintains a voluntary disclosure program that encourages providers to report suspected fraud. The concept of voluntary self-disclosure is premised on a recognition that the Government alone cannot protect the integrity of the Medicare and other Federal health care programs. Health care providers must be willing to police themselves, correct underlying problems and work with the Government to resolve these matters. The OIG's voluntary self-disclosure program has four prerequisites: (1) the disclosure must be on behalf of an entity and not an individual; (2) the disclosure must be truly voluntary (i.e., no pending proceeding or investigation); (3) the entity must disclose the nature of the wrongdoing and the harm to the Federal programs; and (4) the entity must not be the subject of a bankruptcy proceeding before or after the self-disclosure.
If an investigation of an alleged violation is undertaken and the compliance officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those subjects should be removed from their current work activity until the investigation is completed (unless an internal or Government-led undercover operation is in effect). In addition, the compliance officer should take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation. If the hospital determines that disciplinary action is warranted, if should be prompt and imposed in accordance with the hospital's written standards of disciplinary action.

2. Reporting. If the compliance officer, compliance committee or management official discovers credible evidence of misconduct from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the hospital promptly should report the existence of misconduct to the appropriate governmental authority 56 within a reasonable period, but not more than sixty (60) days 57 after determining that there is credible evidence of a violation. 58 Prompt reporting will demonstrate the hospital's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions (e.g., penalties, assessments, and exclusion), if the reporting provider becomes the target of an OIG investigation. 59

58 The OIG believes that some violations may be so serious that they warrant immediate notification to governmental authorities, prior to, or simultaneous with, commencing an internal investigation, e.g., if the conduct: (1) is a clear violation of criminal law; (2) has a significant adverse effect on the quality of care provided to program beneficiaries (in addition to any other legal obligations regarding quality of care); or (3) indicates evidence of a systemic failure to comply with applicable laws, an existing corporate integrity agreement, or other standards of conduct, regardless of the financial impact on Federal health care programs.

The OIG has published criteria setting forth those factors that the OIG takes into consideration when reporting misconduct to the Government, a hospital should provide all evidence relevant to the alleged violation of applicable Federal or State law(s) and potential cost impact. The compliance officer, under advice of counsel, and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. Once the investigation is completed, the compliance officer should be required to notify the appropriate governmental authority of the outcome of the investigation, including a description of the impact of the alleged violation on the operation of the applicable health care programs or their beneficiaries. If the investigation ultimately reveals that criminal or civil violations have occurred, the appropriate Federal and State officials 60 should be notified immediately.

As previously stated, the hospital should take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payor and the imposition of proper disciplinary action. Failure to repay overpayments within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the Government, thereby establishing an independent basis for a criminal violation with respect to the hospital, as well as any individuals who may have been involved.

59 I.e., Federal and/or State law enforcement having jurisdiction over such matter. Such governmental authority would include DOJ and OIG with respect to Medicare and Medicaid violations giving rise to causes of actions under various criminal, civil and administrative false claims statutes.

57 To qualify for the "not less than double damages" provision of the False Claims Act, the report must be provided to the Government within thirty (30) days of the date when the hospital first obtained the information. 31 U.S.C. 3729(a).

56 The OIG believes that some violations may be so serious that they warrant immediate notification to governmental authorities, prior to, or simultaneous with, commencing an internal investigation, e.g., if the conduct: (1) is a clear violation of criminal law; (2) has a significant adverse effect on the quality of care provided to program beneficiaries (in addition to any other legal obligations regarding quality of care); or (3) indicates evidence of a systemic failure to comply with applicable laws, an existing corporate integrity agreement, or other standards of conduct, regardless of the financial impact on Federal health care programs.

58 The OIG has published criteria setting forth those factors that the OIG takes into consideration in determining whether it is appropriate to exclude a health care provider from program participation pursuant to 42 U.S.C. 1320a-7(b)(7) for violations of various fraud and abuse laws. See 62 FR 67392, December 24, 1997.

59 Appropriate Federal and State authorities include the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in the hospital's district, and the investigative arms for the agencies administering the affected Federal or State health care programs, such as the State Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services, the Department of Veterans Affairs and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

60 Appropriate Federal and State authorities include the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in the hospital's district, and the investigative arms for the agencies administering the affected Federal or State health care programs, such as the State Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services, the Department of Veterans Affairs and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

61 See 42 U.S.C. 1320a-7(b)(3).

62 Normal repayment channels as described in HCFA's manuals and guidelines are the appropriate vehicle for repaying identified overpayments. Hospitals should consult with its fiscal intermediary or HCFA for any further guidance regarding these repayment channels. Interest will be assessed, when appropriate. See 42 CFR 405.376.

III. Conclusion

Through this document, the OIG has attempted to provide a foundation to the process necessary to develop an effective and cost-efficient hospital compliance program. As previously stated, however, each program must be tailored to fit the needs and resources of an individual hospital, depending upon its particular corporate structure, mission, and employee composition. The statutes, regulations and guidelines of the Federal and State health insurance programs, as well as the policies and procedures of the private health plans, should be integrated into every hospital's compliance program.

The OIG recognizes that the health care industry in this country, which reaches millions of beneficiaries and expends about a trillion dollars, is constantly evolving. However, the time is right for hospitals to implement a strong voluntary compliance program concept in health care. As stated throughout this guidance, compliance is a dynamic process that helps to ensure that hospitals and other health care providers are better able to fulfill their commitment to ethical behavior, as well as meet the changes and challenges being imposed upon them by Congress and private insurers. Ultimately, it is the OIG's hope that a voluntarily created compliance program will enable hospitals to meet their goals, improve the quality of patient care, and substantially reduce fraud, waste and abuse, as well as the cost of health care to Federal, State and private health insurers.


[FR Doc. 98-4399 Filed 2-20-98; 8:45 am]

BILLING CODE 4150-04-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Program Exclusions: January 1998

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of January 1998, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusion is imposed, no program payment is made to anyone for any items or services (other than an emergency service or service not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party under