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OIG Provides Further Guidance Related to Nursing Facility Compliance Programs

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Last month, the OIG published a draft guidance to supplement its earlier 2000 Compliance Program Guidance for Nursing Facilities. The April 2008 Draft OIG Supplemental Compliance Program Guidance for Nursing Facilities[1] further expands upon potential risk areas, which once finalized will be incorporated with the earlier 2000 guidance into one document.

Before delving into this new 2008 guidance document, facility staff may want to review the 2000 guidance which identifies elements of an effective compliance program. Briefly, the 2000 OIG guidance[2] outlined seven elements which could be incorporated into a three-phase compliance program implementation plan:

- *Phase 1:* Evaluation of significant risk areas for the nursing facility, based upon the type of services offered, the facility's performance history, and potential fraud and abuse areas.
- *Phase 2:* Program development including identifying audit tools, providing employee education, and creating effective lines of communication.
- *Phase 3:* Conducting ongoing auditing and monitoring, with periodic review of the program to be sure that it is effective and current.

The April 2008 draft guidance is devoted to areas identified as potential fraud and abuse risk areas, i.e., those areas that "are currently of concern to the enforcement community." The following provides a brief overview of many of the issues raised under key topic areas.

Quality of Care:

The OIG identifies the theories used to bring "failure of care" cases, in which a nursing facility may face criminal and/or civil liability for care deemed to be so inadequate that it was fraudulent to submit a claim to Medicare or Medicaid for the

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services that were provided. The areas identified to pose significant risks related to the quality of care are:

- *Inadequate Staffing:* which includes an inadequate staff-to-resident ratio or staff skill mix, or may be related to problems associated with high staff turnover or disciplinary problems. Facilities are cautioned to evaluate staffing based on actual payroll data reflecting hours worked, not scheduling data.

- *Comprehensive Care Plans:* noting the prior OIG reports that identified a "significant percentage of resident care plans did not reflect residents' actual care needs;" and, cautioning against a lack of physician involvement in care planning.

- *Medication Management:* highlighting an inappropriate use of psychotropic medications and the lack of a proper medication management process. In particular, the OIG noted the potential conflict of interest and anti-kickback concerns when the consultant pharmacist is associated with the institutional pharmacy used by the facility.

- *Resident Safety:* highlighting not only staff-on-resident abuse and neglect, but also, resident-on-resident altercations. Facilities are cautioned to screen and assess residents for risk of aggressive behavior, as well as, conducting employee screening.

Submission of Accurate Claims

In addition to general guidance prohibiting duplicate billing, billing for services not documented as being provided or not provided at all, or false statements on the cost report, the OIG provide specific guidance regarding:

- *Case-Mix:* noting the inaccurate reporting of RUG rates resulting in upcoding.

- *Therapy Services:* in addition to identifying the potential for overutilization for residents in a Part A stay to inflate the RUG rate and for resident receiving Part B services, the OIG also noted the risk of underutilization resulting in functional declines leading to a failure of care allegation. The key is nursing facility oversight to ensure the delivery of appropriate, medically necessary therapy services.

- *Excluded Individuals:* cautioning facilities to routinely check the OIG's List of Excluded Individuals/Entities and the U.S. GSA's Excluded Parties List System to ensure that claims are not submitted for services provided by excluded individuals or entities.

- *Restorative Services:* noting some services to be so

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"wholly deficient that they amounted to no care at all."

Anti-Kickback Statute

A substantial portion of the OIG draft guidance is devoted to issues that pose a risk of violating the federal anti-kickback statute. The OIG provides a general overview of the anti-kickback statute, including inquiries to identify a "red flag signaling an arrangement or practice may be particularly susceptible to fraud and abuse." Safe harbors under the anti-kickback statute are briefly discussed, as well as, relevant factors to consider for arrangements that do not fall within a safe harbor. Additionally, the following categories of at-risk areas are highlighted:

- *Free Goods and Services:* noting various examples including free pharmacy consultant services offered by the institutional pharmacy servicing the facility, computer equipment provided by the laboratory used by the facility, DME supplies for residents in a Part A stay provided by a facility DME vendor.

- *Service Contracts:* discussing both physician services contracts (e.g., medical director, consulting physician for quality assurance) and non-physician (e.g., therapy services agreements, parenteral and enteral nutrition suppliers, pharmacies) service contracts.

- *Discounts:* including a discussion of price reductions and swapping arrangements.

- *Hospices:* listing various practices which the OIG considers "suspect" under the anti-kickback statute, and referencing the 1998 OIG Special Fraud Alert addressing arrangements between hospices and nursing facilities.

- *Reserved Bed Arrangements:* cautioning that payment by hospitals to nursing facilities to keep certain beds available for the hospital's patients should be limited solely for the purpose of securing the needed bed, not to induce future referrals.

Lastly, the OIG highlighted a few additional risk areas that did not fall within one of the identified categories:

- *Physician Self-Referrals:* Although nursing facility services are not designated health services ("DHS") covered by the physician self-referral or federal Stark law, other services that the nursing facility must bill for under the consolidated billing rules are DHS including laboratory and therapy services. Nursing facilities are cautioned to review arrangements with physicians who order therapy, laboratory tests or other DHS and who have a financial relationship with the facility (e.g., ownership interest, medical director, consulting

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physician).

- *Anti-Supplementation:* ensuring that nursing facilities do not accept supplemental payments for services provided to Medicare and Medicaid beneficiaries because the facility believes the payment to be inadequate to cover the cost of the care.

- *Medicare Part D:* clarifying the expectation that nursing facilities honor a resident's freedom of choice and contract with additional pharmacies if the nursing facility institutional pharmacy will not participate with a particular resident's chosen Part D plan.

- *HIPAA:* requiring compliance with both the Privacy Rule with regard to disclosures of PHI with or without an authorization and the Security Rule's safeguards to protect the confidentiality of electronic PHI.

The 2008 guidance document ends with the OIG noting some compliance program considerations. The OIG reinforces that compliance programs should promote a culture to do the right thing, suggesting that facilities develop a code of conduct or similar document that outlines the ethical and legal principles that guide facility operations. An annual review of the compliance program systems and structure is suggested. And, the OIG suggests the use of a communication tool to ensure that the facility's governing body and senior officers are informed about compliance activities and receive performance-related information.

Although the OIG expressly states that neither guidance document mandates the implementation of a compliance program, nursing facilities that do not have a robust compliance program may want to review these guidance documents and reconsider whether now is the time to implement one or enhance the facility's existing program.

NOTES

[1]The guidance was published in the Federal Register as a draft notice and is available on the Internet at: www.oig.hhs.gov/fraud/docs/complianceguidance/NurseCPGIIFR.pdf. **Comments to this OIG draft guidance are due by June 2, 2008.**

[2]Available on the OIG's Website at: http://oig.hhs.gov/authorities/docs/cpgnf.pdf.

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