COSMOS
Navigate the Compliance Universe

Compliance Today - October 2020
Back to basics: OIG Supplemental Compliance Program Guidance for Hospitals—Risk areas

By Catherine Boerner

Catherine Boerner (cboerner@boernerconsultingllc.com) is President of Boerner Consulting LLC in New Berlin, WI.

- linkedin.com/in/catherineboerner/

The Office of Inspector General's Supplemental Compliance Program Guidance for Hospitals[1] presented the fraud and abuse risk areas listed below that are particularly relevant to the hospital industry. Each hospital should carefully examine these risk areas and identify those that potentially affect the hospital.

It amazes me, as I review this list 15 years later, how the same risk areas are just as relevant today.

1. Submission of accurate claims and information
    a. Outpatient procedure coding
        i. Billing on an outpatient basis for inpatient-only procedures
        ii. Submitting claims for medically unnecessary services by failing to follow the fiscal intermediary's local policies
        iii. Submitting duplicate claims or otherwise not following the National Correct Coding Initiatives guidelines
        iv. Submitting incorrect claims for ancillary services because of outdated Charge Description Masters
        v. Circumventing the multiple procedure discounting rules
        vi. Improperly selecting evaluation and management codes
        vii. Improperly billing for observation services
    b. Admissions and discharges
        i. Failure to follow the same-day rule
        ii. Abuse of partial hospitalization payments
        iii. Same-day discharges and readmissions
        iv. Violation of Medicare's post-acute care transfer policy
        v. Improper churning of patients by long-term hospitals

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website's Terms of Use.

    c. Supplemental payment considerations
        i. Improper reporting of costs of pass-through items
        ii. Abuse of DRG outlier payments
        iii. Improper claims for incorrectly designated provider-based entities
        iv. Improper claims for clinical trials
        v. Improper claims for organ acquisition costs
        vi. Improper claims for cardiac rehabilitation services
        vii. Failure to follow Medicare rules regarding payments for costs related to educational activities
    d. Use of information technology
2. The referral statutes: The Physician Self-Referral Law (Stark Law) and the federal Anti-Kickback Statute
    a. The Physician Self-Referral Law
    b. The federal Anti-Kickback Statute
        i. Joint ventures
        ii. Compensation arrangements with physicians
        iii. Relationships with other healthcare entities
        iv. Recruitment arrangements
        v. Discounts
        vi. Medical staff credentialing
        vii. Malpractice insurance subsidies
3. Payments to reduce or limit services—gainsharing arrangements
4. The Emergency Medical Treatment and Labor Act
5. Substandard care
6. Relationships with federal healthcare beneficiaries
    a. Gifts and gratuities
    b. Cost-sharing waivers
    c. Free transportation
7. HIPAA Privacy and Security rules
8. Billing Medicare or Medicaid substantially in excess of usual charges

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website's Terms of Use.

9. Areas of interest
    a. Discounts to uninsured patients
    b. Preventive care services
    c. Professional courtesy

This document is only available to members. Please log in or become a member.

Become a Member Login

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website's Terms of Use.