



# OIG's New Front On Fraud

*Quality of care as a condition of program participation is a new target for anti-fraud efforts under OIG's new compliance guidance for nursing facilities.*

ON OCT. 15, 2007, THE Social Security Administration announced Kathleen Casey-Kirschling's retirement. That day, she became the first baby boomer to apply for Social Security benefits. In the coming decades, 10,000 Americans per day will follow her.

Similar numbers of Medicare and Medicaid claims will soon follow. The Government Accountability Office estimates that over the next 25 years, between Social Security, Medicaid, Medicare, and other entitlements, the federal government will experience a \$50 trillion shortfall.

## New Vehicles For Action

On Sept. 30, 2008, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued supplemental guidance for nursing facilities seeking to establish compliance programs.

This new guidance, which supplements OIG's 2000 compliance program guidance, provides an expansive discussion of what OIG perceives to be fraud and abuse risk areas, along with remedial steps facilities should take.

It is important for providers to understand that the new guidance makes it very clear that quality of care is the new front in the agency's anti-fraud efforts.

In this fiscal environment, nursing facility operators would be wise to plan for and expect a considerable uptick in the federal government's efforts to recoup funds that it has expended on alleged inadequate care.

To that end, the 2008 guidance warns

that OIG will be looking for "failure of care on a systemic and widespread basis" as grounds for civil and criminal prosecution under the Federal Civil False Claims Act (FCA); the Civil Monetary Penalties law; and other criminal, regulatory, and civil remedies.

## The Pursuit Of False Claims

Until now, the federal government has avoided federalizing medical malpractice law, which has traditionally been left to state regulators; state court judges and juries; and, in egregious cases, prosecutions for elder abuse.

Now, OIG will view substandard quality of care as a form of fraud.

Stripped to its essentials, the new OIG guidance sends a simple message: Provide quality care and implement a robust and meaningful compliance program.

It is important to note that in the 2008 guidance is OIG's express willingness to deploy the FCA in cases involving quality of care.

Of course, FCA cases can only be filed as civil suits, not criminal ones. Criminal cases might be pursued through the federal wire, mail, and health care fraud statutes. The FCA deals particularly with the actual submission of false claims to the government.

Noteworthy for the nursing facility industry is the fact that the FCA allows private individuals to file a false claims lawsuit under seal with the relevant prosecutorial authority. Once a lawsuit is filed, an investigation occurs to determine whether to take an active

role in the case—or intervene—and prosecute it.

## Substantial Awards

If these so-called "private" attorneys general prevail, they may be awarded a significant percentage of the recovery, plus attorneys' fees for their counsel.

If false claims are proven, the provider is liable for three times the amount of the false claim and statutory penalties of \$5,500 to \$11,000 per false claim.

The sums involved can be staggering, and the incentive for a disgruntled employee or family member aware of fraud to file such a claim cannot be ignored.

Moreover, of particular importance is the fact that even if the government does not intervene, the case may still go forward because the FCA permits the whistleblower's lawyer to continue the prosecution without the government prosecutor.

In other words, even the federal government's limited budget cannot keep an FCA case from proceeding, particularly if the plaintiff's bar is creative, sophisticated, and well-funded.

What's more, pending federal legislation known as the False Claims Correction Act of 2007, if passed, would make it far easier to win an FCA case than it is now.

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Among many other proposals, the legislation would eliminate the current requirement that a relator (the individual bringing the FCA lawsuit on behalf of the government) identify specific claims that result from alleged misconduct.

Currently, this requirement alone, in many cases, results in outright dismissals of claims. But the proposed legislation would remove that requirement, making it far easier for the plaintiff to avoid such dismissals.

The technicalities of the FCA are beyond the scope of this article; however, it is clear that such legislation, if passed, will increase the likelihood of FCA cases based on substandard care.

### **Compliance Programs Key**

Bearing firmly in mind that the only thing worse than no compliance program at all is a compliance program given only lip service, a wise provider should implement a robust and effective compliance program that is

internalized at all levels of the corporate structure.

The 2000 OIG guidance document provides an excellent road map for what a compliance plan should look like. Although the 2000 guidance focuses primarily on more traditional billing, kickback, and health care fraud issues, the new guidance conveys that this focus is still necessary but no longer sufficient.

Any viable fraud and abuse compliance program must now include policies, procedures, and training on quality of care as fraud.

At the broadest level, the 2008 guidance suggests targeted training for care providers, managers, administrative staff, officers, and directors on the requirements of 42 Code of Federal Regulations Part 483, which sets forth principal requirements for nursing facilities in the Medicare and Medicaid programs.

More specifically, the 2008 guidance outlines a list of common risk

areas where OIG will look for fraud and abuse, including staffing, care plans, medication management, use of psychotropic medications, and resident safety.

As for staffing, OIG will look beyond theoretical “on-paper” staff to determine whether a provider’s staffing model adequately accounts for case-mix, staff skill level, staff-to-resident ratio, staff turnover, staffing schedules, disciplinary records, payroll records, timesheets, adverse event reports, and staff and family feedback.

For care planning, OIG suggests measures designed to ensure an interdisciplinary and comprehensive approach to developing care plans, such as appropriately scheduled meetings to accommodate the full interdisciplinary team; completing all clinical assessments before the meeting is convened; opening lines of communication between direct care providers, family members, and the team; and documenting the length and context of meetings.

As for medication management, OIG suggests proper processes that advance patient safety, minimize adverse drug interactions, and ensure irregularities are promptly discovered and addressed.

Facilities should employ a licensed consulting pharmacist to train staff on all these issues and should assess psychotropic drug use to ensure they are not being used as improper chemical restraints.

Regarding patient safety, the guidance recommends “policies, procedures, and practices to prevent, investigate, and respond to instances of potential resident abuse, neglect, or mistreatment. ... Confidential reporting is a key component of an effective safety program.”

### **Some Ambiguity**

Facilities should provide a compliance hotline; monitor resident-on-resident abuse, which promises to become an increasing concern; and absolutely must screen staff appropriately.

All these are, of course, necessary and

## Form 990 Revised For 2009 Filings

**T**he IRS recently released the revised instructions that tax-exempt organizations, including not-for-profit long term care facilities, will need in order to complete the redesigned Form 990, which must be filed starting with tax year 2008.

The revised instructions feature several new tools that make it easier to answer questions line-by-line and that facilitate uniform reporting, according to the IRS.

To allow organizations time to adjust to the new forms, the IRS is phasing in the new returns during a three-year transition period. During the transition, an organization’s annual filing requirement will depend on its financial activity.

The IRS advises all filing organiza-

tions to carefully review the new form and instructions in order to ensure that it satisfies the reporting requirements.

Some areas of major changes in reporting requirements cover governance and compensation of officers, directors, trustees, key employees, and highest compensated employees. For example, Part VI is a new section that asks questions about the organization’s governance structure, policies, and disclosure practices.

The IRS also made significant changes that include determination of public charity status and public support; supplemental financial statement reporting; and fund raising, special events, and gaming. For more information, visit [www.irs.gov/charities/article/0,,id=185561,00.html](http://www.irs.gov/charities/article/0,,id=185561,00.html).

appropriate measures that providers should strive to implement. However, the real problem for providers is that quality of care as fraud creates tremendous uncertainty because it produces a very fluid standard of pleading and proof.

Medicare, for example, requires no minimum staffing numbers, relying instead upon facilities to staff sufficiently to maximize resident well-being.

If a resident suffers an adverse event caused by short staffing, does this form the basis for an FCA lawsuit when the facility files a claim for reimbursement for that resident?

Are all claims filed during a period of understaffing “false claims” such as to give rise to treble damages and statutory penalties?

The same questions can be asked about the other focus areas. How poor, for example, must care planning be before it gives rise to the possibility of an FCA lawsuit? Medication management? Patient safety?

Everyone in this industry knows how quality-of-care cases have yielded nine-figure verdicts in negligence cases, and there is no reason to believe the same passions would not drive decisions in the FCA arena initially in a prosecutor’s decision to sue or indict and later in a judge’s decision whether or not to permit a case to proceed beyond the pleading stage and beyond a jury verdict.

**Be Prepared**

Experience teaches us that, as a practical matter, a lawyer dealing with a prosecutorial agency has, by far, the greatest leverage before that agency has become entrenched in a position and before a decision to bring charges is a foregone conclusion.

This leverage is most effective when the targeted provider can demonstrate good corporate citizenship and compli-

ance as part of the corporate culture and ethics.

Often, the first question out of a prosecutor’s mouth is whether staff have internalized a provider’s compliance program and, if so, why the compliance program failed in the particular case being investigated.

But a facility that has adopted rigorous compliance as part of its culture is highly unlikely to be prosecuted.

The 2008 guidance, read through the demographic and fiscal lens, may well signal rough seas ahead. The best protection against those rough seas is to begin planning for them now. ■

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