Comparing the OIG Guidances

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One of the first places to begin when creating a compliance program is the Office of Inspector General (OIG) compliance program guidances, designed to help healthcare organizations develop and implement effective programs. These documents (available online at http://www.hhs.gov/oig) include specific guidelines from the OIG on the fundamental elements of a compliance program and the essential principles for implementation.

To date, the OIG has issued guidances for clinical laboratories, hospitals, home health agencies, third-party medical billing companies, hospices, Medicare+Choice organizations, and nursing facilities. All of these plans have some common features, and they are based on the same key elements. (See "Seven Elements of Effective Compliance Programs," page 30.) But they are not all identical. For example, identified risk areas vary according to the type of healthcare organization. See the following table for a comparison of the risk areas outlined in the compliance program guidances for hospitals, home health agencies, nursing facilities, and hospices.

While the OIG's guidelines present basic procedural and structural information, they do not constitute a compliance program. Instead, they offer issues to consider as you develop a compliance program tailored to your organization's culture, size, structure, and operational processes.

The following chart illustrates areas of specific risk for each care setting, with special areas of risk noted.

Risk Area	**Hospital (2/98)**	**Home Health (8/98)**	**Nursing Facilities (3/00)**	**Hospice (9/99)**
Patient's freedom of choice	X			
Failure to refund credit balances	X	X	X	
Kickback violations	X	X		X
Joint ventures	X	X		
Financial arrangements between hospitals and hospital-based physicians	X			
Violations of Stark physician self-referral law	X	X		
Knowing failure to provide covered services or necessary care to HMO members	X			
Patient dumping	X			
Billing for services provided to patients who are not homebound		X		Admitting patients to hospice who are not terminally iyll
Billing for visits to patients who do not require qualifying service		X	Submitting claims to Medicare Part A for residents not eligible for Part A coverage	

Overutilization and underutilization		X		Underutilization
Billing for items or services not rendered	X	X	X	
Providing medically unnecessary services	X	X	X	X
Upcoding	X		X	
DRG creep	X			
Outpatient services rendered in connection with inpatient stay	X			
Teaching physician and resident requirements for teaching hospitals	X			
Duplicate billing	X	X	X	Arrangement with another healthcare provider whom the hospice knows is submitting claims for services already covered by Medicare hospice benefit
False cost reports	X	X	X	
Unbundling	X		X	
Billing for discharge in lieu of transfer	X			
Knowingly billing for inadequate or substandard care		X	X	X
Insufficient documentation to evidence that services were performed to support reimbursement		X	Failing to maintain sufficient documentation to support diagnosis, justify treatment, document course of treatment and results, and promote continuity of care	
Billing for unallowable costs of home health coordination		X		
Billing for services provided by unqualified or unlicensed clinical personnel		X	Inadequate or insufficiently trained staff to provide medical, nursing, and related services	X

False dating of amendments to nursing notes		X		False dating of amendments to medical records
Falsified plans of care		X		
Untimely and/or forged physician certifications on plans of care		X	Forging physician signatures on documents used to verify services were ordered	X
Forged beneficiary signatures on visit slips/logs that verify services were performed		X	Forging beneficiary signatures on documents used to verify that services were performed	
Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services		X		X
Inadequate management and oversight of subcontracted services		X		X
Discriminitory admission and discharge of patients		X	Discriminitory admission or improper denial of access to care	
Billing for unallowable costs associated with acquisition and sale of home health agencies		X		
Compensation programs that offer incentives for number of visits performed and revenue generated		X		Sales commission based on length of stay in hospice
Improper influence over referrals by hospitals that own home health agencies		X		
Patient abandonment		X		
Knowing misuse of provider certification numbers		X		X
Duplication of services provided by assisted living facilities, hospitals, clinics, physicians, and other home health agencies		X		Overlap in services that nursing home provides
Knowing and reckless disregard of willing and able caregivers		X		
Failure to adhere to licensing requirements and Medicare conditions of participation		X		X
Knowing failure to return overpayments		X		X

Billing for items or services not ordered			X	
Providing misleading information about resident's medical condition on MDS or otherwise providing inaccurate information used to determine RUG assigned to resident			X	
Billing for individual items or services when they either are included in the facility's per diem rate or are the type of item or service that must be billed as a unit and may not be unbundled			X	
Altering medical records			X	Falsified medical records and plans of care
Absence of comprehensive, accurate assessment of each resident's functional capacity and comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs			X	
Inappropriate or insufficient treatment and services to address residents' clinical conditions, including pressure ulcers, dehydration, malnutrition, incontinence of the bladder, and mental or psychosocial problems			X	
Failure to accommodate individual resident needs and preferences			X	
Inadequate staffing levels or insufficiently trained or supervised staff to provide medical, nursing, and related services			X	
Failure to provide appropriate therapy services			X	
Failure to provide an ongoing activities program to meet the individual needs of all residents			X	
Inappropriate or insufficient treatment and services to address resident's clinical conditions			X	Inadequate or incomplete services rendered by interdisciplinary group
Failure to properly prescribe, administer, and monitor prescription drug usage			X	
Failure to provide appropriate services to assist residents with activities of daily living			X	
Failure to report incidents of mistreatment, neglect, or abuse to facility administrator and other officials as required by law			X	

Verbal, mental or physical abuse, corporal punishment, and involuntary seclusion			X	
Inappropriate use of physical or chemical restraints			X	
Failure to ensure that residents have access to their records upon request and that privacy and confidentiality of those records are protected			X	
Denial of resident's right to participate in his or her own care and treatment			X	
Failure to safeguard residents' financial affairs			X	
Improper indication of location where hospice services were delivered				X
Uninformed consent to elect Medicare hospice benefit				X
Insufficient oversight of patients, in particular, those patients receiving more than six consecutive months of hospice care				X
Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals				X
Providing hospice services in nursing home before written consent has been finalized, if required				X
Pressuring patients to revoke Medicare hospice benefit when patient is still eligible for and desires care				X
Deficient coordination of volunteers				X
Failure to comply with applicable requirements for verbal orders for hospice services				X
Non-response to late hospice referrals from physicians				X

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