

[We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requester.]

Issued: March 9, 2000

Posted: March 16, 2000

[Name & Address of Requestor]

Re: OIG Advisory Opinion No. 00-1

Dear [Name Redacted]:

We are writing in response to your request for an advisory opinion concerning a consulting firm's contractual payment arrangements for the performance of auditing services to identify hospital undercharges and overcharges associated with private payors (the "Arrangement"). Specifically, you have inquired whether the Arrangement constitutes grounds for sanctions under the anti-kickback statute, section 1128B(b) of the Social Security Act (the "Act").

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the totality of the facts present in the Arrangement, as described and certified in your request letter and supplemental submissions, the Office of Inspector General ("OIG") will not subject Company A, the requestor of this opinion, to sanctions for violations of the anti-kickback statute under sections 1128(b)(7) or 1128A(a)(7) of the Act in connection with the Arrangement.

This opinion may not be relied on by any persons other than Company A and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

Company A is a consulting organization that enters into contracts with hospitals to audit hospital bills for undercharges (hospitals claiming too little) and overcharges (hospitals claiming too much) to private insurers paying on a charge basis.⁽¹⁾ Company A audits only cases in the following three hospital service areas: labor and delivery, endoscopies (gastrointestinal), and surgeries.⁽²⁾ Company A does not audit or review any charges for services provided by ancillary departments (e.g., lab tests and x-rays).

Company A provides services in three phases: (i) Company A audits hospital records for undercharges and overcharges on bills issued during the twelve-month period before the effective date of the contract between Company A and the hospital and on bills issued during the audit, and works with payors to reconcile incorrect bills ("Phase I"); (ii) Company A holds a post-audit session during which it presents the Phase I audit report findings to hospital nursing directors of the service areas covered by the audit to prevent undercharges and overcharges in the future ("Phase II"); and (iii) Company A conducts a six-month follow-up audit to monitor hospital improvement using the same procedures applied in Phase I ("Phase III").

Hospitals compensate Company A by paying Company A [x]% of the amount that the hospitals recover through Phase I. Company A audits only those items or services billed on a charge-basis. Company A does not audit amounts paid on the basis of diagnosis or procedure related groups or codes.

Company A does not audit bills reimbursed by the Federal or State health care programs, whether as primary or secondary payors. The Arrangement including Phases II and III does not involve any Federal or State health care program business, directly or indirectly. Company A has instituted the following procedure for excluding

Federal and State health care program business. Company A first eliminates any bills for patients who are 65 years of age or older. For the remaining hospital bills, Company A identifies a patient's primary and secondary insurers from the UB-92 form (which is the same as the HCFA-1450 form, also used by other Federal and State health care programs). The Federal and State health care programs will not pay a claim without a designation on the UB-92 form stating that they are primary or secondary payors. If the UB-92 form reflects that a Federal or State health care program (including CHAMPUS and the Title XXI children's health insurance program) is a primary or secondary payor, Company A will not review that patient's charges.

II. LEGAL ANALYSIS

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by any Federal health care program. See section 1128B(b) of the Act. Specifically, the statute provides that:

Whoever knowingly and willfully offers or pays [or solicits or receives] any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person -- to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony.

Id. Thus, where remuneration is paid purposefully to induce referrals of items or services for which payment may be made by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. The OIG may also initiate administrative proceedings to exclude persons from Federal and State health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.⁽³⁾

As a threshold matter, we recognize that the Arrangement only applies to non-Federal health care program billing practices and would appear not to implicate the anti-kickback statute. The mere "carve-out" of Federal health care program billing, however, does not end our inquiry, since such arrangements could have a "spillover" effect on billing or coding for Federal health care program items or services. Where such effect occurs and is intended by one or both parties, the statute may be implicated.

In this case, the Arrangement poses a limited risk of fraud or abuse under the anti-kickback statute. First, Company A has certified that the Arrangement does not involve Federal health care program business, directly or indirectly. Second, the principal activity under the Arrangement is a one-time, wholly retrospective billing audit. Such audits raise few questions under the anti-kickback statute because where items or services have been entirely ordered, provided, and claimed prior to the audit, there is little risk that the audit will involve an improper referral under the anti-kickback statute.⁽⁴⁾ Third, the prospective portions of the Arrangement, Phases II and III, are limited in nature and present few, if any, opportunities for spillover effects on Federal health care program billing or coding.⁽⁵⁾

Accordingly, based on the totality of the facts present in the Arrangement, we conclude there is a minimal risk that the Arrangement will have an adverse effect on Federal health care program business.

For the above reasons, including, without limitation, Company A's representation that the Arrangement will not involve Federal health care program business in any respect, we will not subject Company A to sanctions arising under the anti-kickback statute in connection with the Arrangement. No opinion is herein expressed or implied regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct directly or indirectly related to the Arrangement.

III. CONCLUSION

Based on the totality of the facts present in the Arrangement as described and certified in the request letter and supplemental submissions, the OIG will not subject Company A to sanctions for violations of the anti-kickback statute under sections 1128(b)(7) or 1128A(a)(7) of the Act in connection with the Arrangement.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Company A, the requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requestor to this opinion.
- This advisory opinion is applicable only to the statutory provisions specifically noted above in the first paragraph of this opinion. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Arrangement.
- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.
- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those that appear similar in nature or scope.
- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the requestor with respect to any action that is part of the Arrangement taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the requestor with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented, and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/s/

D. McCarty Thornton
Chief Counsel to the Inspector General

1. Company A also offers managed care payment review services to hospitals. Such services are outside the scope of this advisory opinion.
2. In its advisory opinion request and supplemental submissions, Company A specified in detail its procedures for identifying undercharges and overcharges contained in hospital bills. For purposes of this advisory opinion, it is sufficient to note that the auditors search for errors in a hospital's charging and billing by comparing the patients' medical records to their billing records. In performing its audits, Company A uses the charge protocols that existed at the time the hospital originally determined the charges for a given procedure.
3. Because both the criminal and administrative sanctions related to the anti-kickback implications of the Arrangement are based on violations of the anti-kickback statute, the analysis for purposes of this advisory opinion is the same under both.
4. We have identified a number of risk areas, including false claims liability, with respect to the operation of third party billing companies. See The Office of Inspector General's Compliance Program Guidance for Third-Party Medical Billing Companies (Nov. 24, 1998), reprinted in 63 Fed. Reg. 70,138 (Dec. 18, 1998). Institutions and individuals are legally responsible for the appropriateness of claims submitted by third party billing companies to Federal or State health care programs on their behalf.
5. Our determination not to impose sanctions in these circumstances is attributable to the entirety of the facts of the Arrangement. In other circumstances, prospective advice and training programs could implicate the anti-kickback statute, False Claims Act, and other legal authorities. By way of example only, such statutes may be violated if a hospital pays a consultant based on a percentage of collections to train the hospital's coders to characterize services in ways that may result in upcoding of the services being ordered.