

Home Care COMPLIANCE ALERT™

This Issue

Fraud & Abuse: OIG To Continue Eyeing DME Suppliers.....42

Audits: Providers May Ask About Andersen, But CMS Won't Tell.....43

HIPAA:
• Proposed Changes Help, But Countdown Continues.....44
• Provide Practical Examples For Privacy Training.....44

Kickbacks: 6 Ways To Improve Patient Copay Collection.....45

Compliance Plans: Your Compliance Plan May Have Teeth, But Does It Bite?.....46

Risk Management:
• Ruling With An Iron Fist Can Increase Medication Errors.....47
• Avoid Autocratic Supervisors.....48

Labor Law: DOL Backtracks On Limiting Companionship Exemption.....48

Compliance News.....49

Vol. 6, No. 5
Pages 41-50
May 2002

OASIS

FOCUS ON OUTCOMES — YOUR SURVEYOR WILL

Home health agencies that stay mired in the process-focused survey procedures of the past will be seeing more deficiencies when surveyors move to the clinical outcomes-focus of the future.

Using outcome-based quality improvement (OBQI) reports, surveyors now can narrow their focus more than ever to target problem areas, explained consultant **Pat Sevast** with Baltimore-based **American Express Tax & Business Services**, speaking in a recent **Eli** teleconference. Surveyors are likely to move quickly in this direction because it will allow for more effective use of resources in the expensive survey process. That's because surveyors will be able to use OBQI reports to pinpoint problem agencies and focus their ire on them.

HHAs can prepare for the change by taking advantage of OBQI information. Act now, Sevast counseled, so you have time to show improvement on next years' OBQI reports and in the interim can demonstrate to surveyors that you are addressing problem areas. She outlined a four-part process.

1. Start by choosing only one or two target outcomes to work on. "Don't expect to change the world" with this process, Sevast warned.

To decide what to work on, first highlight those outcomes on your report that have one or two asterisks next to them, she said. Then look at the magnitude of the difference between your result and the national reference result for these outcomes. One outcome with two asterisks may have a 5 percent differential and another may have a 25 percent differential — choose an outcome with a higher magnitude, she instructed.

Next, look at the number of cases. You don't have to choose the largest, but you should choose an outcome that "impacts a large number of patients," Sevast advised.

Fraud & Abuse

OIG TO CONTINUE EYEING DME SUPPLIERS

If the HHS Office of Inspector General's latest Medicare improvement recommendations are any indication, durable medical equipment suppliers will remain in the hot seat in the year ahead. (Page 32)

Also consider how important the outcome is to your agency's goals, she said. An agency that has a high percentage of rehab patients may want to focus on a different outcome than an agency with many wound care patients.

2. Identify what you want to change.

Involve all the disciplines and as many outside resources as possible in an effort to define "the ideal care for this target outcome" before you look at patient charts, she advised. Experts in the target area and local or national associations can be very helpful. Your goal is to find the best practices in patient care, Sevast explained.

Once you determine the ideal care, compare what you did for your patients to what you should have done. Include case conferences and home visits along with audits. When auditing patient records, select your sample of at least 30 records from a focused group of patients where the target outcome is significant, Sevast said. For example, look at hip replacement patients when addressing transfer skills. Your case mix reports will help you choose your patient focus, she added.

3. Develop a plan of action. Define as problems the actions you found lacking, Sevast explained. Focus on two to four changes you can make to improve the outcome. Be specific about the behaviors you expect, she emphasized. State how often the nurse should do something, when to report changes, where to document the action and how to monitor the activity.

Then determine how you will change care providers' behavior. "Just another in-service" is not enough, Sevast urged. Consider approaches such as one-on-one training, visual prompts, visits with staff, changes in forms, clinical in-service training and new techniques or supplies.

4. Monitor your results. Behavior change is difficult, Sevast reminded listeners. Staff feedback, patient surveys and monthly or quarterly chart audits will keep your plan on track.

Even though using OBQI reports is voluntary, "surveyors will expect [agencies] to have identified problems," Sevast said. And if surveyors see an agency working toward solutions, they may be more lenient about applying deficiencies, she speculated. Agencies also may find unexpected improvements in documenta-

tion and medical review results from their efforts, she predicted. ❖

Fraud & Abuse

OIG TO CONTINUE EYEING DME SUPPLIERS

If the **HHS Office of Inspector General's** latest Medicare improvement recommendations are any indication, durable medical equipment suppliers will remain in the hot seat in the year ahead.

The *2002 Orange Book*, released April 16, includes the **OIG's** most "significant, unimplemented, nonmonetary" recommendations that generally require administrative action "not substantially completed," the agency explains. Five out of the six DME recommendations are new this year, the report notes, with more recommendations focusing on DME suppliers than on any other provider type.

Suppliers that provide blood glucose test strips should note the **OIG's** concerns about missing or flawed documentation, claims submitted at irregular intervals and abusive marketing practices.

Indeed, blood glucose test strips are a major audit focus right now, warns attorney **Tom Antone** with Washington-based **Mintz Levin Cohn Ferris Glovsky & Popeo**.

To avoid some of the most common errors, experts suggest suppliers:

- dispense new supplies only after the patient specifically requests them;
- document that you had contact with the patient before you shipped the supplies;
- ensure that the file contains the physician's prescription before you bill and that the prescribed frequency of testing agrees with the quantity of supplies sent;
- avoid routine waiver of deductible or co-payment (*see related article p. 45*);
- refund payment if patient returns supplies;
- eliminate any patient freebies, such as free monitors, that may be deemed kickbacks; and
- include start/end dates on claims forms.

Suppliers need to be sure they have a current copy of the supplier's manual for their region and a complete set of DME regional carrier bulletins, and then read everything in there about blood glucose test strips, Antone urges. All of these materials are available on the **DMERCs'** Web sites, he adds.

The OIG also thinks beneficiaries pay too much for DME because they don't understand the effects of participating supplier status and assigned versus unassigned claims (*see HCCA Vol. 5, No. 3, p. 24*). The **Centers for Medicare & Medicaid Services** continues to assert that, once it has published a final rule on the issue, it plans to use its "inherent reasonableness authority" to address concerns about reimbursement for ostomy supplies, which account for a high percentage of unassigned claims.

And CMS plans to expand the online Participating Physician Directory to include suppliers, the OIG reports. Meanwhile, in its January 2001 response to the watchdog agency, CMS expressed less concern than the OIG about the number of participating providers, since "95 percent of provider claims are accepted on assignment" for DME.

Suppliers may head off possible legislative efforts to address balance billing — the portion of DME charges that exceeds the Medicare-allowed amount — by educating beneficiaries about the medical equipment Medicare benefit, effectively

using advance beneficiary notices and accepting assignment whenever possible, experts say.

Concurring with another OIG concern, CMS says it plans to move bi-level ventilators from the "frequent and substantial servicing" payment category to the capped rental category, saving Medicare \$11.5 million annually.

Finally, suppliers that fail to comply with "the 11 supplier standards" will find themselves subject to more frequent site visits, the OIG reports. Some suppliers violated inventory, liability insurance and licensing standards, says the OIG in the *Orange Book*. And more than half failed to provide adequate consumer information.

This last concern is somewhat outdated, Antone argues, since as of December 2000 suppliers must comply with 21 standards, most of which are consumer-focused. One of these standards requires suppliers to disclose the supplier standards to the beneficiary, and DMERCs do audit for this, Antone warns. Suppliers routinely meet this requirement by including the standards as part of a

Audits

PROVIDERS MAY ASK ABOUT ANDERSEN, BUT CMS WON'T TELL

Home care providers who thought the **Enron** scandal wouldn't affect them are not so sure following the **General Services Administration's** government-wide suspension of Enron's accounting firm, **Arthur Andersen**.

The GSA suspended Andersen March 15, following the **Department of Justice's** March 14 indictment of the auditing firm for obstruction of justice. The DOJ alleges that Andersen destroyed "literally tons of paper documents and other electronic information related to the Enron inquiries," according to Deputy Attorney General **Larry Thompson**.

Many providers are concerned about the effect of this suspension on organizations using Andersen as their independent review organization under corporate integrity agreements with the **Centers for Medicare & Medicaid Services**.

"In the interest of causing minimal disruption to providers' ongoing business operations and reducing the financial burden to providers of having to engage another firm to duplicate work already performed by Andersen, the OIG has decided to waive the CIA requirements that would result in immediate cessation of Andersen's involvement in the provider's Federal health care program operations," says the **HHS Office of Inspector General** in an FAQ released April 12.

The OIG warns that once current contracts with Andersen expire, the provider is barred "from entering into, renewing or extending engagements with Andersen." And providers not bound by a CIA should confirm with CMS "whether the provider has any additional obligations with respect to Andersen flowing from its Medicare provider agreement," the OIG adds.

But that's easier said than done. Asked whether that means CMS is excluding Andersen, a CMS official tells **Eli**, "We're taking GSA's guidance on this. It is not up to CMS as to whom facilities may make business decisions to contract with." ❖

Editors Note: To see the FAQ entry, go to <http://oig.hhs.gov/fraud/cia/docs/ciafaq1.html#7>.

“setup package” of forms and information they review with each beneficiary, Antone reports. But don’t forget the crucial step of having the beneficiary sign *and* date her receipt of the information, he advises. ❖

Editor’s Note: The Orange Book is at <http://oig.hhs.gov/publications/orangebook.html>.

HIPAA

PROPOSED CHANGES HELP, BUT COUNTDOWN CONTINUES

Cheer for the **Department of Health and Human Services’** proposed amendments to the HIPAA privacy rule — but don’t stop working toward compliance.

Responding to health care industry pressure HHS proposes to remove consent requirements for information disclosures connected with treatment, payment and health care operations (TPO), according to a notice published March 27 in the *Federal Register*.

HHS’ proposal addresses many providers’ concerns about inconvenience or interference with patient care, and home care providers will be pleased, predicts attorney **Bill Roach** with **Gardner Carton & Douglas** in Chicago. Deleting the consent requirement eliminates any need to distinguish between consent and authorization and allows for better sharing of PHI between health care providers, he notes.

HHS proposes changes in these areas:

- **Consent.** Instead of requiring covered entities to secure consent to use protected health information (PHI) for TPO, the proposed rule requires patients simply to acknowledge receipt at some point of a covered entity’s privacy policy. A use or disclosure for non-TPO purposes still would require a signed authorization.

- **Minimum necessary.** The rule’s “minimum necessary” standard, which requires covered entities to limit the use of PHI, attracted industry complaints that routine conversations among health care professionals would violate the rule. HHS proposes to add a new provision to the final rule that “explicitly permits certain incidental uses and disclosures” so long as “the covered entity has applied reasonable safeguards.”

- **Business associate contracts.** Covered entities would gain a year after the compliance deadline to revamp their business associate contracts to ensure that associates will comply with the privacy regulations.

- **Marketing.** Marketing remains an area where HHS is reluctant to stand down. While the revisions narrow the definition of marketing, the proposal explicitly would require covered entities to obtain an individual’s specific authorization before sending them any marketing materials.

But the HIPAA privacy deadline has not changed: Home care providers must comply with the rule — regardless of changes — by April 14, 2003. “There is still going to be a lot an agency must address,” says attorney **John Gilliland** with Indianapolis-based **Gilliland & Caudill**. Notice of privacy practices, privacy policies and administrative requirements will require action, he says, and when agencies review what is required, “they will realize there is still much to do.”

And HHS “came down on the side of patient privacy” when it comes to marketing, Roach stresses. The proposal eliminates marketing from the definition of health care operation and defines marketing more clearly, he says. Providers will need specific patient authorization for most marketing functions, Roach cautions, which “will be a challenge for marketing departments.”

Revising the rule at such a late date may cause even more headaches for covered entities than the revisions will relieve. “Some people are saying this is the end of HIPAA as a major topic of conversation, but I don’t think so at all,” says **Bill Sarraille**, with **Arent Fox Kintner Plotkin & Kahn** in Washington. “It’s still going to be a major implementation hassle for folks.” ❖

HIPAA

PROVIDE PRACTICAL EXAMPLES FOR PRIVACY TRAINING

If your entire organization isn’t trained and ready for HIPAA privacy compliance by this time next year, fines and penalties await you.

With the Health Insurance Portability and Accountability Act’s privacy requirements taking effect in April 2003, many home care providers are beginning to train staff on compliance. But training must include all levels in your organization, experts agree.

“You can’t say, ‘OK, I’m going to train the top three people in my organization and therefore I’m going to be done with my HIPAA privacy training because they’re going to understand everything and will be there to answer questions,’” warned **Kristen Baum** of Joliet, IL-based **Murer Consultants**, speaking at a recent **Eli** teleconference on HIPAA privacy training. “That’s not going to cut it. The rule is very specific about having everyone in your organization trained on privacy.”

Failing to train all staff comes with a hefty price tag, co-presenter **Michael Murer** pointed out. Civil penalties under HIPAA carry fines of \$100 per incident, capped at \$25,000. However, the cap applies only to violations of the same requirement — if you violate different sections of the rule, you could face multiple civil violations.

Even worse, knowing violations of the regulations carry criminal fines of as much as \$50,000 or a year in prison. And tort lawyers are likely to use the law to sue providers for damages, experts say.

Providers need to create an effective training program, Murer says, and such a program should be:

1. Functional. A training program that takes a purely theoretical approach won’t work. Instead, it should be built around real-life examples. “Make examples interesting,” Murer urged. “Give a lot of detail so [trainees] say, ‘This is like a case we had. This is like something that we’ve seen.’”

2. Analytical. Give trainees a chance to talk about how to apply the rule in different cases — not only to improve their understanding of the rule, but also to improve your organization’s compliance efforts. “You need to be able to find the people who understand what it is that you’re trying to teach them, so that they can be the [knowledge] base for that part of the organization,” he explained.

3. Matrixed. Health care organizations deal with many different kinds of staff, professional and nonprofessional, as well as outside contractors, and that creates a complex matrix of relationships, Murer pointed out. “Who can have what information, who can’t have what information, where are the limits, how is the information transmitted — all of these are concerns of your training program,” he noted.

As an example, he described a scenario where a provider’s accountant reviews a patient’s file for billing purposes, then attends a cocktail

party where he sees the patient’s physician. What, if anything, can the accountant say?

And what happens when a janitor sees a patient’s records lying on a clinician’s desk? Effective HIPAA training would address these situations, the presenters said.

“Organizations in health care know how to treat patients, how to bill, how to administer,” Murer said. “Now they have to learn how to protect individually identifiable health information.” ❖

Kickbacks

6 WAYS TO IMPROVE PATIENT COPAY COLLECTION

Beware, durable medical equipment suppliers: Your competitors might advertise that their patients don’t have to pay anything, but if you respond in kind, you may find yourself losing cash flow *and* paying fines.

In the recently released *2002 Orange Book*, the **HHS Office of Inspector General** reminds providers that routinely waiving patient coinsurance amounts is a kickback (*see related article p. 42*).

“It’s something I see every day,” says **Jane Wilkinson-Bunch**, president of Marietta, GA-based consulting firm **JB & C**. Doctors often tell patients they won’t owe anything, and rather than upset the patient or referral source, suppliers write off the 20 percent copay “without realizing the consequences,” she explains. Even when a supplier does know it’s a problem, if a competitor uses “no copay” as a marketing tool, the supplier may think, “I can do it a few times and not get caught,” but of course they usually do,” Wilkinson-Bunch says.

Suppliers traditionally are reluctant to pursue copays vigorously because “they have a soft heart” and because they don’t find it to be the best use of limited resources, asserts Redmond, CA-based consultant **Roberta Domos** with **Domos HME Consulting**. Most providers do make a good faith effort, Domos says, but “actually pursuing those accounts until they are collected is at the bottom of the priority list.”

People seem to think that service from equipment suppliers is free, laments Wilkinson-Bunch, and education is the key to changing this. “Your referral sources aren’t going to write off 20 percent, and neither should you,” she admonishes.

The Publication Of Record For Home Care Compliance. To Subscribe, Call 1-800-874-9180.

Comments or suggestions? Please call Marian Cannell, JD, RN at 1-800-626-9714.

Experts offer the following suggestions for making copayment collection as painless and consistent as possible:

1. Educate your referral sources. Never be negative about competitors who waive copayments, just explain the regulations, Domos suggests. Provide a written statement about the regulations and explain that you “take Medicare compliance seriously, as you’re sure the referral source does as well,” she adds.

2. Educate your intake staff. Don’t just sit an employee at the phone and give him a form to fill out, warns Wilkinson-Bunch. Good intake is a key to your company’s success, she says, and the intake staff need to know as much as possible about the “big picture.”

3. Ask patients to pay the copay upon delivery. This gives you an opportunity to educate the patient about her responsibility, and find out if the doctor told her it would be free, explains consultant **Miriam Lieber** with Burbank, CA-based **Lieber Consulting**. Some companies develop attractive brochures explaining the Medicare Part B benefit and the patient’s responsibility for the 20 percent copay, she notes. Others provide copies of the brochure Medicare supplies for patients.

4. Consider accepting credit card payment. This will resolve many collection problems, Wilkinson-Bunch predicts, but often suppliers are unaware of this option.

5. Seriously pursue copay collection efforts. It’s both good business and good compliance, experts agree. Make sure billing staff understand the Medicare regulations and the consequences of not collecting copays, Domos recommends. Make one person responsible and accountable for private pay collections, she says, and then monitor the results.

6. Bill the patient even if she says she “can’t pay.” You never know when a patient’s financial situation may change, Lieber notes. Besides showing your attempts to collect, it is the initial step in documenting the patient’s indigent status if you do need to write off the copay.

“It’s absolutely not true that you just need to bill a patient three times and have her write on each bill that she can’t afford to pay,” Wilkinson-Bunch instructs. Fill out a financial hardship form and be sure the patient is “meeting the national poverty guidelines,” because the supplier is responsible for showing that the patient can’t pay, she counsels. ❖

Compliance Plans

YOUR COMPLIANCE PLAN MAY HAVE TEETH, BUT DOES IT BITE?

If you have never punished anyone for compliance violations, the feds are likely to judge your plan ineffective — and hand down a punishment of their own.

You need to enforce your compliance rules for two reasons, according to attorney **Linda Baumann** with **Reed Smith** in Washington. Doing so will ensure that your compliance program is effective, and it will make you look better in the eyes of the **HHS Office of Inspector General**.

Indeed, OIG auditors will be suspicious if they see that no one in your organization has been punished for violating your compliance program, Baumann warns. They don’t expect you to have a high body count of fired employees, but if no one has ever gotten in trouble, auditors will take that as a sign you aren’t serious about compliance.

This is especially important if auditors turn up compliance problems. If they find a major violation, ask what you did to the employee responsible for it and you reply “nothing,” you’re asking for trouble, warns attorney **Donna Thiel** of **Morgan Lewis & Bockius** in Washington.

Be impartial when enforcing compliance rules, Baumann notes. Auditors “expect you to discipline consistently, so you’re not supposed to just dump on the low-level types when senior people were really at fault.” In fact, managers should be responsible for making sure their subordinates know about — and follow — compliance rules. “Managers should be sanctioned if they fail to hold up their end of it,” Baumann says.

Include in your compliance policies what the punishments will be for infractions. Thiel recommends having “a tiered structure,” in which certain minor violations lead to minor penalties, escalating so that worse violations — and/or repeat violations — result in termination.

“You don’t want to have the death penalty for a minor violation,” Thiel notes. But on the other hand, if an employee does commit a major violation and you need to let her go, the termination process is easier if you can point to a pre-existing policy as your reason. This way there are no negotiable “gray areas” — your punishment guidelines explain ex-

actly what to do in each situation, and managers don't need to make difficult judgment calls.

In such situations, Thiel explains, managers can say, "We'd love to hang on to you, but as you can see, with our policy, we must fire you. Otherwise, we'll get in trouble with the OIG."

You should elucidate the different tiers of discipline in your personnel policies, recommends attorney **John Gilliland** of **Gilliland & Caudill** in Indianapolis. Give examples of which infraction would result in which penalty, but be sure to note that this is not all-inclusive, and that there may be other potential infractions.

Warning letters also are effective in telling an employee to shape up. Having your boss say you're doing something wrong is one thing, Gilliland notes, but it feels a lot more serious when your boss hands you something in writing telling you to pay closer attention to compliance rules or else. Such an official notice "is a real wake-up call," Gilliland says.

Don't go overboard with your punishments, Baumann says. There will be some honest mistakes, especially with newer employees. In such situations, sometimes "discipline" simply can consist of more training.

Document every violation and every disciplinary action, Baumann notes. This way you have something to point to, should the OIG swing by.

Thiel cautions managers against docking or suspending staff's pay lest you run into problems with the Fair Labor Standards Act. Balancing labor laws and Medicare compliance can be difficult, and managers should work with their attorneys to make sure they're always in the right, Baumann adds. ❖

Risk Management

RULING WITH AN IRON FIST CAN INCREASE MEDICATION ERRORS

If you want to avoid allegations of poor quality of care — and steer clear of the resulting civil monetary penalties and Medicare exclusion — you may want to improve the quality of your supervisors.

To err may be human, but the magnitude of the problem could surprise providers, according to a survey report **The Commonwealth Fund** released April 15. "Twenty-two percent of respondents reported that they or a family member had experienced a medical error of some kind," the report

noted, with only one-third of the prescription drug errors occurring in hospitals.

"Supervision plays a key role in compliance both in preventing medication errors and in identifying and reporting them," warns consultant **Linda Stock Rutman** with Charlotte, NC-based **Larson Allen Health Care Group**. Yet medication administration rarely is competency-tested in the field or periodically observed in supervisory visits, she notes.

In home care the goal is to prevent medication errors by both staff and patients, Rutman says. Educate staff on the basics of safely administering all types of medication, she recommends, and emphasize that they must clarify any questions about a medication before giving it, either by using reference material or by contacting the pharmacist.

Insist on careful documentation of both the medication administered and the patient's reaction.

If a medication error does occur, have a procedure for the nurse to follow. Rutman suggests these five steps:

1. Assess the patient for her reaction.
2. Notify the doctor, seek orders and implement these as needed. Document actions taken and the patient's reaction. The documentation does not need to be specifically designated "medication error."
3. Establish any necessary emergency plan changes with the patient.
4. Complete a confidential agency "occurrence report."
5. Consult with the supervisor about a "performance improvement plan."

Reporting errors is important in learning about their causes and in preventing future errors, experts agree, but a punitive work environment will discourage reporting. It also increases anxiety, which actually can increase errors, says Dr. **Tony Grasha**, professor of psychology at the **University of Cincinnati** (see related article p. 48).

Clinicians usually are already upset about making the error, Rutman says, so providers should strive to make reporting it less stressful. It helps to have supervisors who can "foster a collegial confidence in staff members," she explains. "Supervision must walk the fine line between appropriate admonition for failure to comply with procedure and ego support for human error," she adds.

Many "psychosocial factors" contribute to medication errors, and the supervisor-employee

The Publication Of Record For Home Care Compliance. To Subscribe, Call 1-800-874-9180.

Comments or suggestions? Please call Marian Cannell, JD, RN at 1-800-626-9714.

relationship is an important one, explains Grasha. Supervisors with a “controlling micro-managing style” are a problem because they don’t give “appropriate autonomy to professionals,” he tells **Eli**.

Providers may want to ask employees how they would rate their supervisors. In studies Grasha has conducted to investigate pharmacy errors, he found a clear correlation between staff who made fewer mistakes — and also were more satisfied with their jobs — and their perception of the quality of their supervision.

Have supervisors participate in quality improvement activities, and don’t stop before finding the “root cause” for any errors, Rutland warns. Ferreting out the source of the problem educates the staff while preventing a pattern of errors, she concludes. ❖

Labor Law

DOL BACKTRACKS ON LIMITING COMPANIONSHIP EXEMPTION

Home health agencies using minimum wage and overtime exemptions for aides and homemakers have convinced the feds that economics matters — but check state laws before celebrating.

The **Department of Labor** has pulled the proposal it made in January 2001 to limit the Fair

Labor Standards Act companionship exemption to cover only workers directly employed by families or individuals (*see Eli’s HCCA Vol. 5, No. 3, p. 28*). Regulations currently allow agencies and others an exemption from paying companions for the elderly and infirm minimum wage and overtime under FLSA.

The DOL proposal would have affected even agencies that already pay minimum wage and overtime to these workers, since it would have required them to include travel time in the calculation of hours worked, experts tell **Eli**. The FLSA requires employers to pay non-exempt employees time and one-half for all hours worked over 40 a week.

The **California Association for Health Services at Home** calculated that paying companions overtime would result in a 17 percent rate increase for overnight companions and a 60 percent increase for 24-hour live-in companions, notes CAHSAH’s **Joe Hafkenschiel**. The shortage of companion workers would make spreading shifts out to avoid overtime very difficult, CAHSAH pointed out.

Comments lambasting the proposal from government entities such as the **Small Business Administration** and the **Department of Health and Human Services** caused the DOL to reconsider its judgment that the change would have “little economic impact,” the agency says in the April 8 *Federal Register* notice announcing the withdrawal.

RISK MANAGEMENT

AVOID AUTOCRATIC SUPERVISORS

Quality supervision requires a manager who oversees work and provides feedback effectively. If your supervisors are untrained in doing this, your error rate may soar.

Since effective supervision is associated with fewer medication errors, employers should train people with supervisory responsibilities in effective interpersonal and supervisory skills, suggests Dr. **Tony Grasha**, professor of psychology at the **University of Cincinnati** and a researcher in the area of medication errors. Supervisors need to be able to “work with people” rather than just “telling them what to do,” he says.

According to Grasha, effective supervisors:

- Encourage excellence and set clear goals for employees.
- Promote high standards for a job and then delegate effectively so the employee can meet those standards.
- Assign responsibility for a task and then allow appropriate independence on the job.
- Discuss expectations clearly and hold people accountable.
- Help employees set priorities for task completion.
- Motivate employees and help them feel involved and important.
- Encourage staff to work as a group to solve problems, helping them think about how to work more effectively. ❖

But not all states have laws recognizing this exemption, experts tell **Eli**. In states that don't, agencies must continue abiding by FLSA minimum wage and overtime requirements for companion workers, they warn. ❖

Compliance News

'DURASCAM' LEADS TO HUNDREDS OF ARRESTS

The next time you enter into a business arrangement, you might want to behave as if your new partner is an undercover FBI operation — many Los Angeles providers wish they had.

What began as a crackdown on fraudulent durable medical equipment suppliers in southern California in 1998 has expanded to become the largest undercover medical fraud investigation in U.S. history, involving suppliers, labs, chiropractors, pharmacies, insurance companies and docs. Using the new pattern of interagency cooperation, the joint venture includes four major state **Federal Bureau of Investigations** offices, the **Department of Justice**, the **Internal Revenue Service** and numerous state agencies, the *Los Angeles Times* reports.

Operation "Durascam" still is going strong, with nearly 400 arrests so far and many more to come, FBI agents told the *Times*. The FBI set up its own clinic, with agents posing as physicians and patients, and spent two years dealing with DME suppliers and labs. Providers offered the clinic kickbacks to exaggerate or falsify documents justifying the need for wheelchairs, oxygen concentrators, body braces and other DME, the FBI said.

• **In response to a Florida Association of Medical Equipment Services lawsuit filed April 3** against Florida's **Agency for Healthcare Administration**, AHCA "has agreed to temporarily stop the [state's Medicaid competitive bidding] process until May 31," FAMES says. AHCA won't open the cost proposals that home medical equipment suppliers have submitted, the association adds. For additional information on the suit go to www.famesonline.org.

• **The Centers for Medicare & Medicaid Services** April 22 unveiled on its Web page the first issue of the promised Quarterly Provider Update. The Update lists Medicare and Medicaid regulations CMS has issued during the previous three months, as well as rules the agency has under development. The Update, indexed by provider type, also lists program transmittals, program memoranda and other instructions. It's at www.cms.hhs.gov/providerupdate/.

According to the Update, CMS plans to withdraw its proposed rule for upgraded DME, which the agency replaced with its new advance beneficiary notice policy. CMS also plans a 2003 update to the home health prospective payment system and electronic cost reporting for hospices.

• **A new initiative launched April 23** by the **Health Care Compliance Association** could make it easier to demonstrate that a provider's compliance plan is effective. At its 2002 Compliance Institute in Chicago, HCCA announced a public and private sector effort to develop "generally accepted performance measurement standards" (GAPMS) for health care compliance programs.

The standards will be crafted to allow organizations to measure compliance program performance and to quantify the return on investment of compliance initiatives. **Stephan Vincze**, compliance officer for **TAP Pharmaceuticals** and an HCCA board member, will lead the program measures task force, which will include both compliance officers and officials from the **HHS Office of Inspector General** and CMS. The task force aims to finalize a hospital measurement checklist by the end of the year, then move on to other segments of the health care industry.

• **Home care organizations seeking a one-year extension** to the compliance deadline for the Health Insurance Portability and Accountability Act transactions standard now can submit the **Department of Health and Human Services'** model request form either by mail or electronically — once the CMS Web site can accept it. The model form is available at the CMS site: www.cms.gov/hipaa/hipaa2default.asp. CMS will provide a confirmation number for electronic filers as proof of filing.

ELI'S HOME CARE COMPLIANCE ALERT AVAILABLE ONLINE

As a paid subscriber, you can now receive *Home Care Compliance Alert* by e-mail...for FREE. Send an e-mail with your name, company, zip code, and phone number to: HCCAonline@eliresearch.com, and we'll sign you up. Questions? Call our customer service team at 1-800-874-9180. Thank you!

The Publication Of Record For Home Care Compliance. To Subscribe, Call 1-800-874-9180.

Comments or suggestions? Please call Marian Cannell, JD, RN at 1-800-626-9714.

Providers either must comply with the standards by Oct. 16, 2002 or submit the extension request by that date outlining their plans to achieve compliance, including projected target dates for accomplishing certain compliance activities. The four-page model plan CMS issued March 29 contains 26 questions about HIPAA awareness, operational assessment and development and testing that basically require checking "yes" or "no".

• **Palmetto GBA saved the federal government \$663.9 million** nationally through its various payments safeguard activities in fiscal 2001, the contractor says. The **Blue Cross Blue Shield of South Carolina** subsidiary processes Part A claims for North Carolina and South Carolina, handles Part B for South Carolina, and serves as the Region C durable medical equipment regional carrier and regional home health intermediary.

• **An Agawam, MA durable medical equipment supplier has agreed** to pay \$375,000 to settle charges that it overbilled the Medicaid program between 1994 and 2000, Massachusetts Attorney General **Tom Reilly** reports. Prosecutors maintain that **Agawam Medical Supply Corp.**, which does not admit to the allegations, billed too much for incontinence wet wipes and non-sterile latex gloves. As part of the settlement, Agawam will submit annual reports to the AG's office verifying its compliance with Medicaid rules.

• **InTrust Plus Home Medical Equipment in Des Moines, IA has received a warning letter** from the **Food and Drug Administration** for failing to perform tests on a bulk liquid oxygen storage tank or on truck-mounted vessels being filled from the tank, according to the *Warning Letter Bulletin*.

Separately, **Pulmonaire Service** of Chattanooga, TN has received a letter accusing it of failing to perform similar tests, document prefill tests on cryogenic home units, obtain a certificate of analysis for oxygen it used to calibrate an oxygen analyzer and document employee training.

• **Home health nurse Regina Waites pleaded guilty** March 27 to Medicaid fraud resulting from submission of faked time sheets and nursing notes to **Tri-State Home Health and Equipment**, which billed Medicaid for her skilled care of a patient, according to Maryland Attorney General **Joseph Curran Jr.** During hundreds of the hours

she supposedly was caring for the home health patient, Waites also was working in another facility, Curran says.

• **A Bangor, ME former home health aide scheduler, Jeffers Ashley is suing St. Joseph Healthcare's Home Health and Hospice Department**, claiming it discriminated against him because he was handicapped and male, reports the *Bangor Daily News*. Ashley alleges that his female supervisor made anti-male remarks and complained about him parking in a handicapped spot although he qualified to do so. Only four of the HHA's 90 employees were men, the paper says.

St. Joseph says in a statement it hasn't reviewed the complaint and points out that none of Ashley's allegations involve patient safety, according to the *Daily News*. ♦

☒ Eli Research

Home Care COMPLIANCE ALERT

Subscriptions: (800) 874-9180

Fax: (919) 544-3147

Web Site: <http://www.eliresearch.com>

Marian Cannell JD, RN, Editor in Chief (800) 626-9714

Emily Simpson, Senior Editor (800) 871-9013

Erin Core, MA, Managing Editor (888) 812-6939

Rebecca Johnson, Executive Editor (888) 234-5896

Roland McReynolds, JD, Publisher (919) 484-0099

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

Eli Research Home Care Compliance Alert™, ISSN: 1525-3473, is published monthly, 12 times a year, by Eli Research, Inc., PO Box 90324, Washington, DC 20090-0324. Annual subscription price is \$257. Subscriptions are also available in e-mail PDF format. Bulk pricing available.

WARNING: Unauthorized photocopying or e-mail forwarding is punishable by up to \$100,000 per violation under federal law. We'll share 50% of any proceeds if you report violations to Roland McReynolds, JD, 1-800-457-8953, rolandm@eliresearch.com.

Periodicals postage paid at Durham, NC and at additional mailing offices. Postmaster send change of address to Eli Research Home Care Compliance Alert, 2327 Englert Drive, Suite 202, Durham, NC 27713. © Eli Research.