OIG NEWS RELEASE

For Immediate Release
Wednesday, October 21, 1998

Contact: Judy Holtz (202) 619-0893
Ben St. John (202) 619-1028

OIG Issues Guidance On Voluntary Disclosure of Health Care Fraud

The Department of Health and Human Services's Office of Inspector General (OIG) today unveiled an expanded and simplified program for health care providers to voluntarily report fraudulent conduct affecting Medicare, Medicaid, and other Federal health care programs.

Called the Provider Self-disclosure Protocol, it replaces a voluntary disclosure program pilot tested by the OIG over a two-year period. The Protocol, which is effective immediately, provides detailed guidance to health care providers that decide voluntarily to disclose irregularities in their dealings with the Federal health care programs. It will be published in the Federal Register and posted on the OIG's Internet site (www.hhs.gov/progorg/oig).

Unlike the pilot program, which was only available to certain health care providers in a few states and had strict eligibility requirements, the new program is open to all providers nationwide under significantly relaxed requirements for participation. While not protected from civil or criminal action under the False Claims Act, providers disclosing fraud are advised in the Protocol that the self-reporting of wrongdoing could be a mitigating factor in OIG's recommendations to prosecuting agencies.

"Major modifications have been made to the voluntary disclosure program in response to the needs of the many honest providers trying to do the right thing," Inspector General June Gibbs Brown said in announcing the revisions. "We have sought to address the concerns of the provider community by removing disincentives to participation while at the same time emphasizing that providers have a legal and ethical duty to identify and correct incidents of non-compliance with program requirements."

The pilot voluntary disclosure program was introduced in 1995 as part of Operation Restore Trust (ORT), a major anti-fraud initiative aimed at dishonest durable medical equipment, home health care, nursing home, and hospice care providers in California, Florida, Illinois, New York and Texas. To be eligible, an applicant had to be a corporate entity doing business in one of the ORT States in one of the provider industries being examined. Moreover, a participant had to disclose a matter that was not already under investigation by or known to a Federal or State law enforcement authority. In addition, the participant was required to sign an agreement to fully cooperate with authorities.

These requirements have been dropped from the Protocol. Now all health care providers doing business with Medicare, Medicaid or other Federal health care programs that want to disclose violations of law are eligible for acceptance into the program. There are no pre-disclosure requirements, applications for admission, or preliminary qualifying characteristics that must be met. If, after an initial assessment, a provider uncovers suspected fraud or other problems involving the Federal health care programs, the provider is urged to report the discovery to the OIG. The provider will have the option of doing a self-audit in conformance with OIG guidance. The Protocol offers a detailed step-by-step explanation of how a provider should proceed in reporting and assessing the extent of wrongdoing and how the OIG will go about verifying irregularities.

Self-reporting offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation, to negotiate a fair monetary settlement, and to avoid an OIG permissive exclusion preventing the entity from doing business with the Federal health care programs. Because a provider's disclosure can involve anything from a simple error to outright fraud, the OIG is not making any commitments as to how a particular disclosure will be resolved or the specific benefit that will enure to the disclosing entity. Providers are simply told that full disclosure and cooperation generally benefits the individual or company, and that OIG will report on the provider's involvement and level of cooperation to the Department of Justice or other government agency affected by the disclosed matter.

Providers can benefit from using the self-disclosure protocol if resolution of the problem includes the imposition by the OIG of a Corporate Integrity Agreement (CIA). Providers under CIAs must meet government-imposed strictures to better ensure their compliance with program requirements. The OIG reports that there are two distinct benefits which a provider may expect when it enters into a CIA as part of the resolution of a voluntary disclosure:

1. Annual audits of an entity's billing operations that are required in CIAs, may be performed by internal or external auditors. Normally a CIA could require these annual audits to be performed by an independent review organization, such as a law firm or an accounting firm.

2. To the extent that any obligations required by the CIA replicate provisions that already exist in an entity's own voluntary corporate compliance program, those provisions may be deemed acceptable for the purpose of the entity meeting its obligations under the CIA.

"In establishing this new guidance, we are renewing our commitment to promote an environment of openness and cooperation," Inspector General Brown stated, adding, "we believe that we must continue to encourage the health care industry to conduct voluntary self-evaluations and provide viable opportunities for self-disclosure. The government alone can not successfully win the battle against health care fraud; health care providers must be enlisted in this effort."

As greater numbers of providers voluntarily adopt compliance programs, the OIG believes that the Provider Self-disclosure Protocol will serve as the mechanism for them to alert the

government when an internal audit uncovers a systemic billing abuse or a hotline caller reports a fraud scheme.

Several providers contacted the OIG about self-disclosure options after the pilot program was launched, and nearly $8 million was recovered. The most recent settlement, in the amount of $840,000, was reached this week with Deborah Heart and Lung Center, a 161-bed, non-profit hospital in Browns Mills, N.J.

-30-