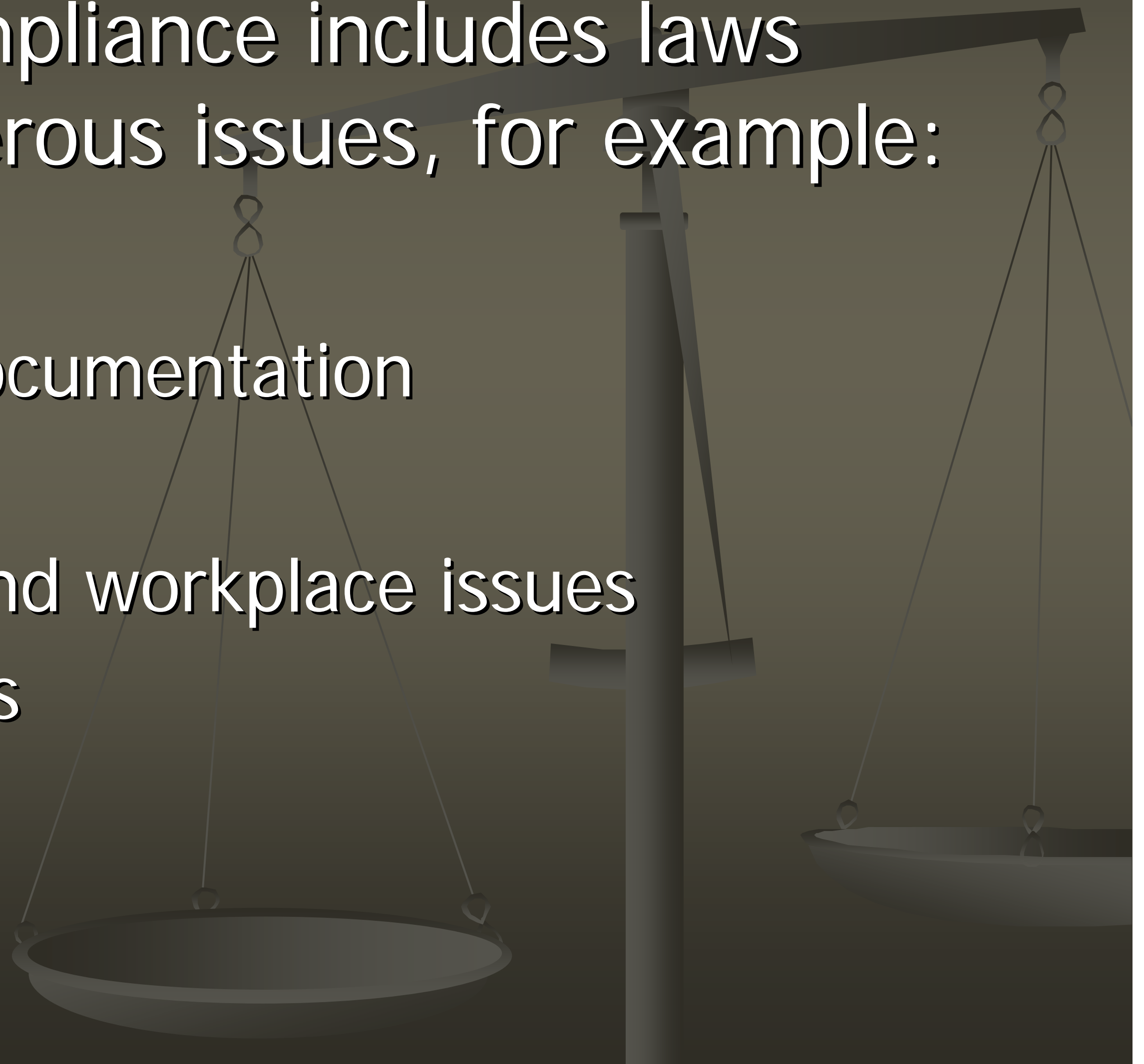
Provider CME

"the process of meeting the expectations of others."

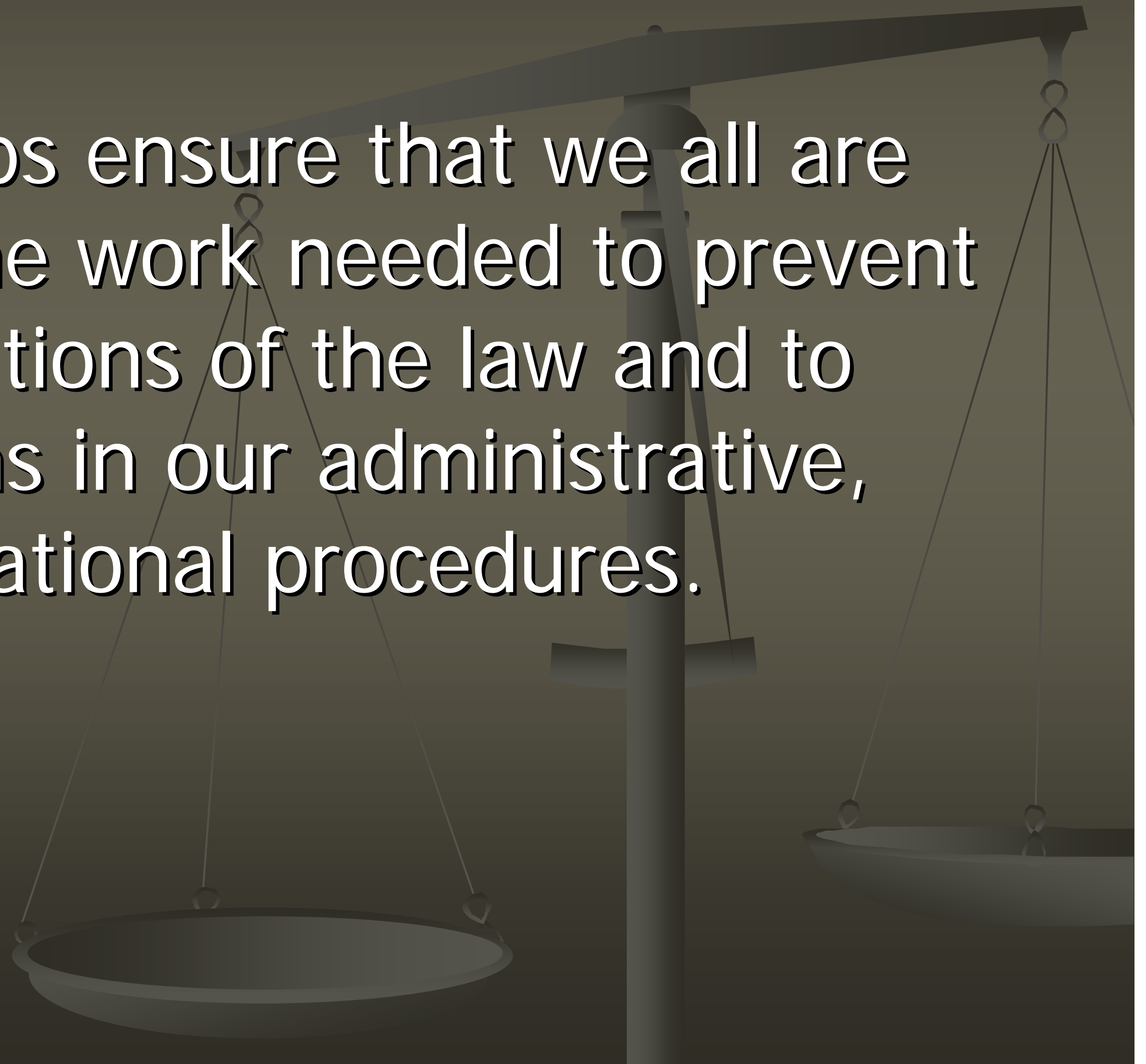
Source: Healthcare Compliance Association

Healthcare Compliance

- Health care compliance includes laws related to numerous issues, for example:
  - patient care documentation
  - quality of care
  - employment and workplace issues
  - licensure issues

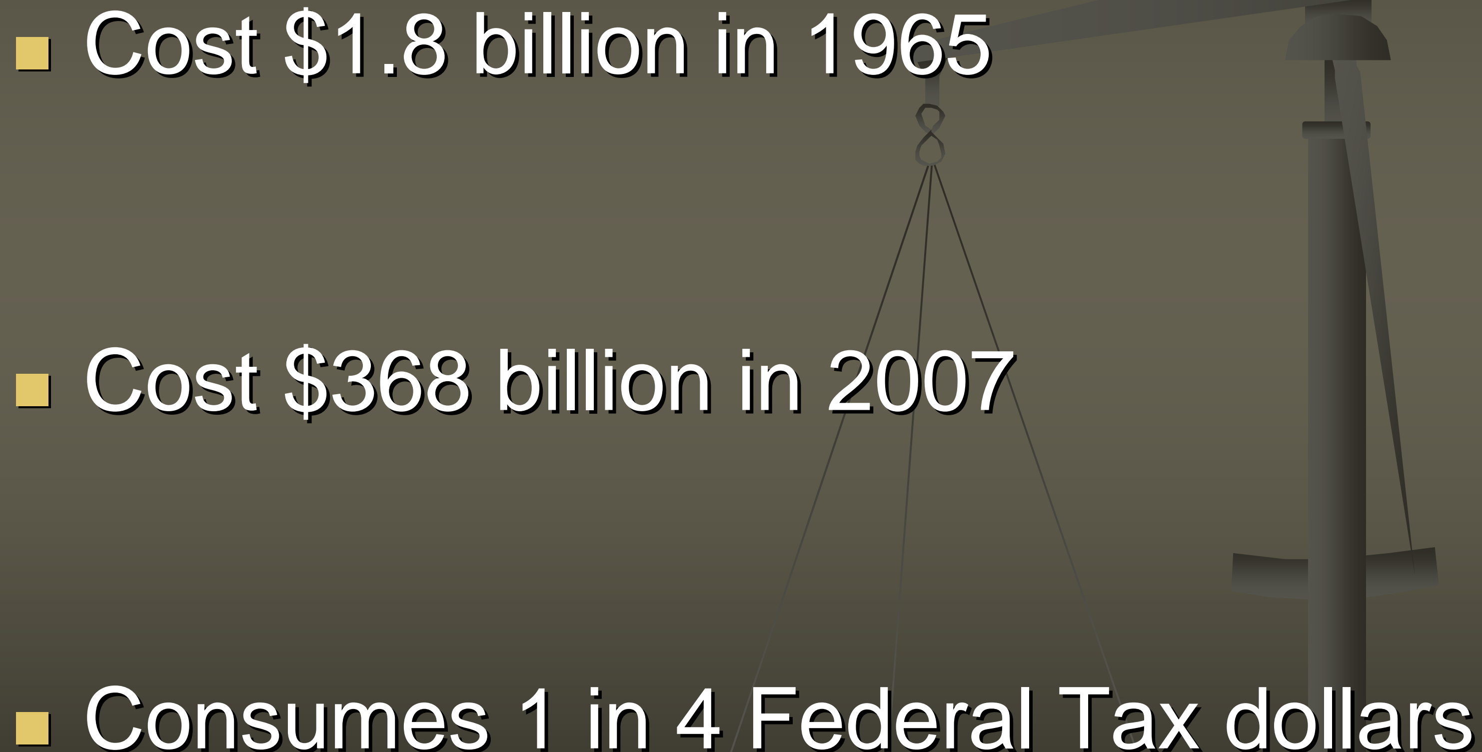


Role of Compliance



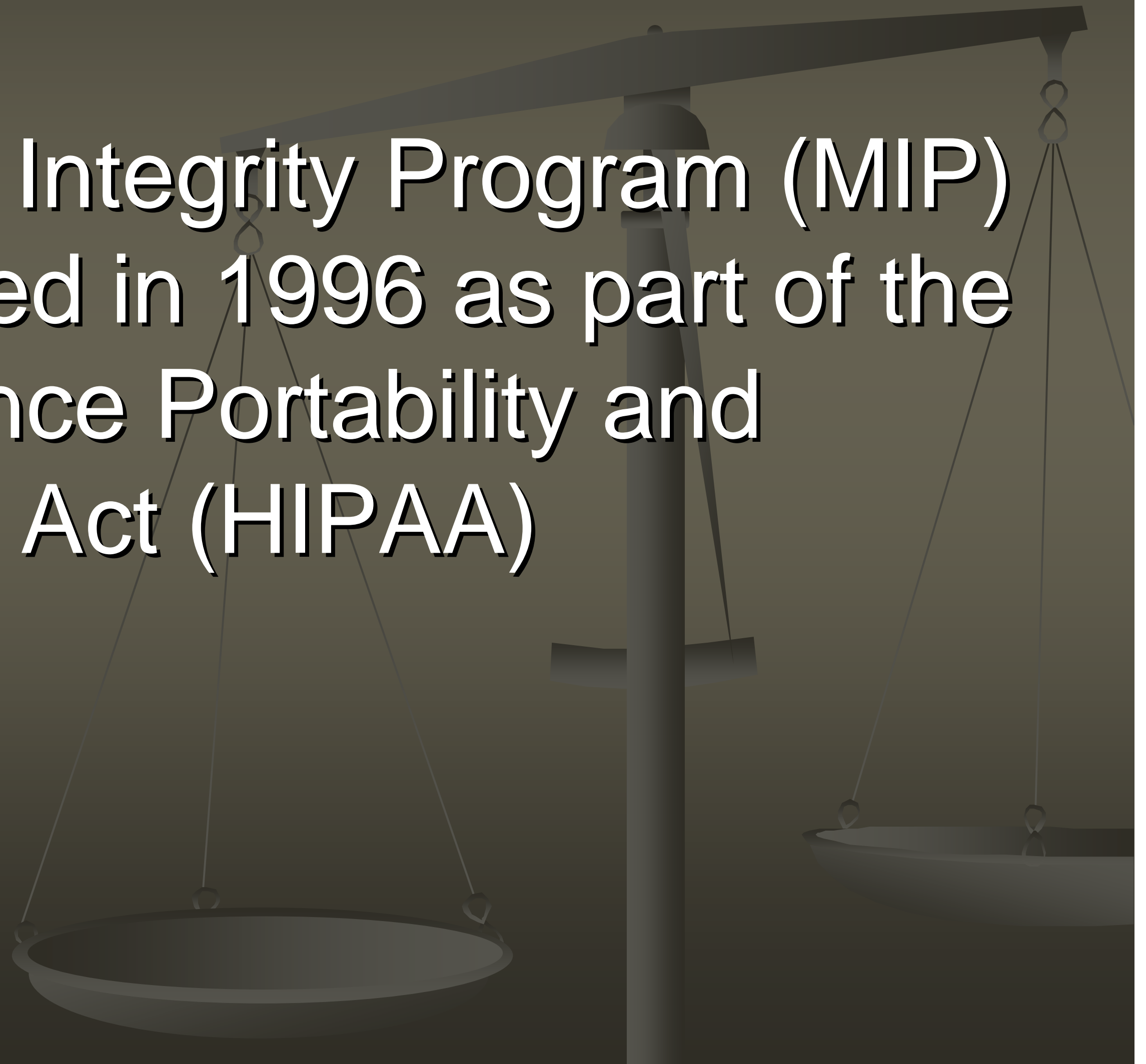
- Compliance helps ensure that we all are committed to the work needed to prevent and detect violations of the law and to make corrections in our administrative, billing and operational procedures.

Some perspective regarding Medicare Expenses



- Cost $1.8 billion in 1965
- Cost $368 billion in 2007
- Consumes 1 in 4 Federal Tax dollars

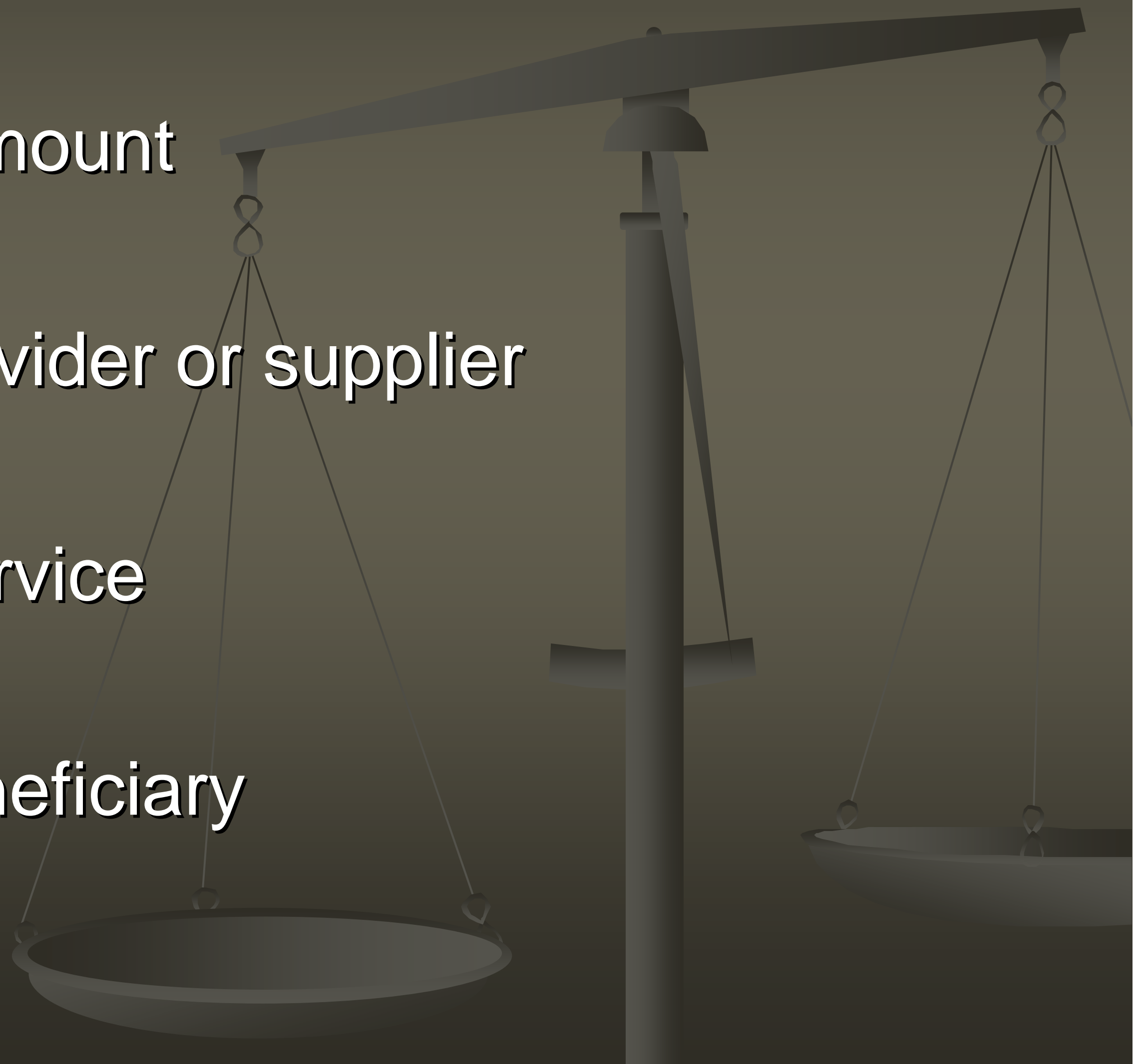
Medicare Integrity Program



- The Medicare Integrity Program (MIP) was established in 1996 as part of the Health Insurance Portability and Accountability Act (HIPAA)

Medicare Integrity Program

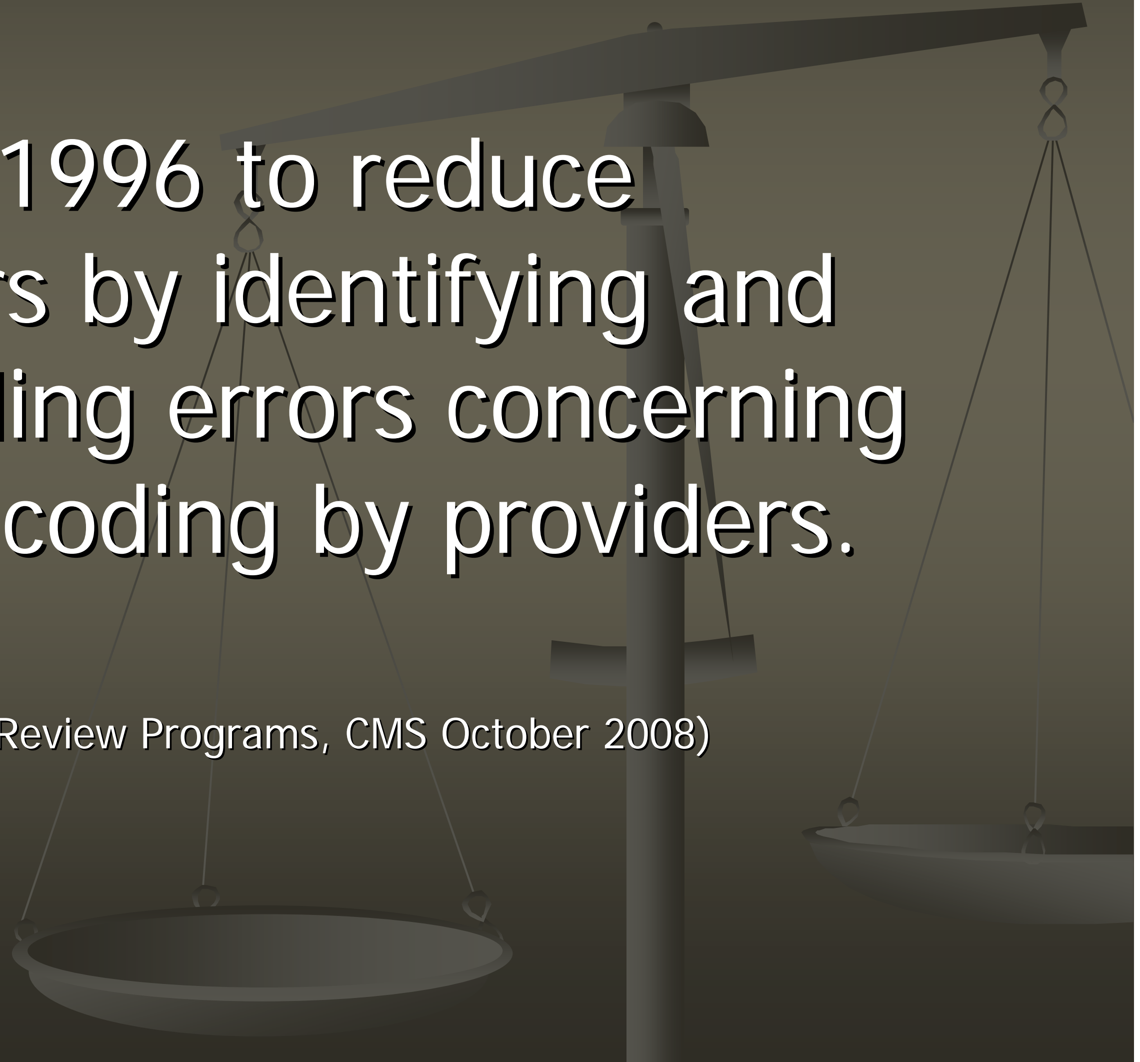
- Goal:
  - Pay the right amount
  - To the right provider or supplier
  - For the right service
  - To the right beneficiary



Medicare Claims Review Program

- Implemented 1996 to reduce payment errors by identifying and addressing billing errors concerning coverage and coding by providers.

(Source: Medicare Claim Review Programs, CMS October 2008)



Medicare Claims Review

- The Improper Medicare FFS Payments Report May 2008 showed that " 3.7% of Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing or payment rules"

- This equates to $10.2 billion annually

(Source: Medicare Claim Review Programs, CMS October 2008)

Medicare Contractors conducting Claims Reviews

- Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs) conduct reviews
- Program Safeguard Contractors (PSCs) are responsible for identifying cases of suspected fraud and taking corrective actions

- Source: CMS Medicare Claims Review Programs: MR,NCCI Edits, MUEs, CERT and RAC October 2008

Medicare Claims Review Audits

- Pre-payment
  - National Correct Coding Initiatives (CCI) edits
  - Medically Unlikely Edits (MUE)
  - Carrier/FI/MAC Medical Review
- Post-payment
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Audit Contractor (RAC)
  - Carrier/FI/MAC Review

- Source: CMS Medicare Claims Review Programs: MR,NCCI Edits, MUEs, CERT and RAC October 2008

What is Healthcare Fraud?

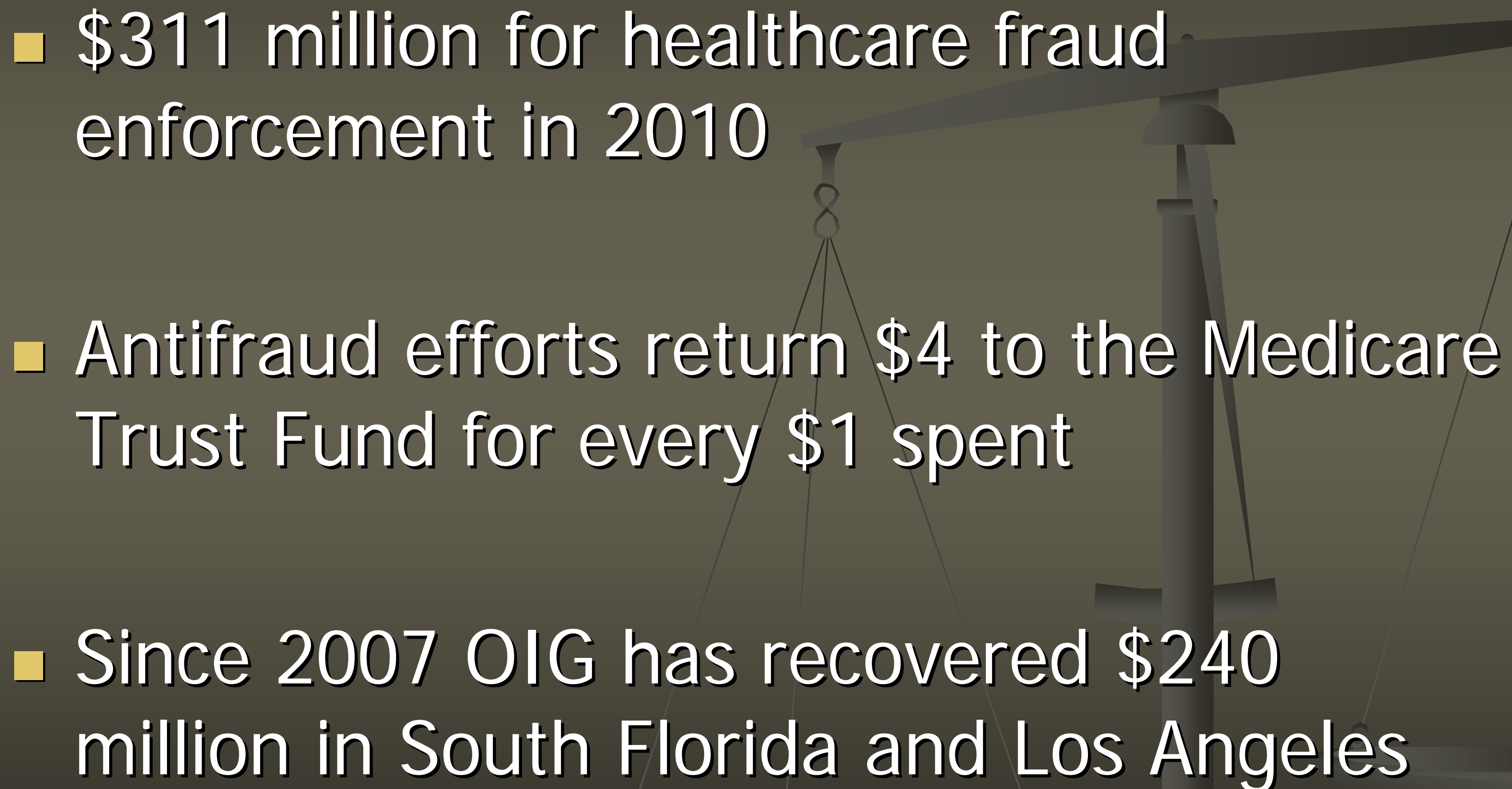
- "knowingly and willfully executing or attempting to execute, a scheme or artifice to defraud any health care benefit program"

- Source: Title 18, U.S.C. §1347

Medicare Fraud

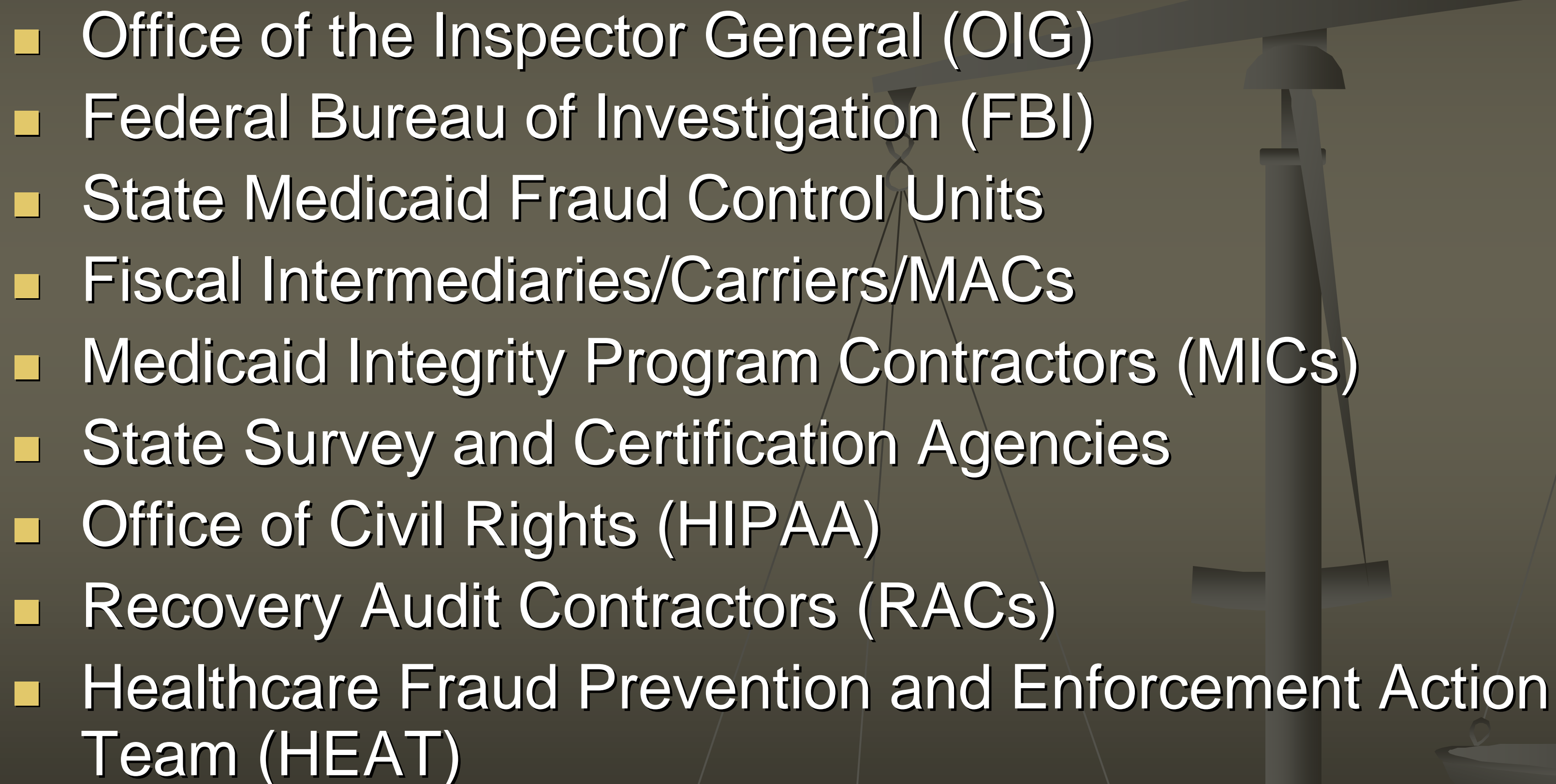
- $60 billion annually due to fraud
- “To put the $60 billion in fraud in perspective, Medicare loses seven times as much money in fraud every year than the combined profits of the 14 health insurance companies on the Fortune 500.”
- Source: money.cnn.com/magazines/fortune/fortune500/2009/industries/223/index.html.)

Medicare Fraud Enforcement



- $311 million for healthcare fraud enforcement in 2010
- Antifraud efforts return $4 to the Medicare Trust Fund for every $1 spent
- Since 2007 OIG has recovered $240 million in South Florida and Los Angeles

Government Agencies involved in Fraud Investigations

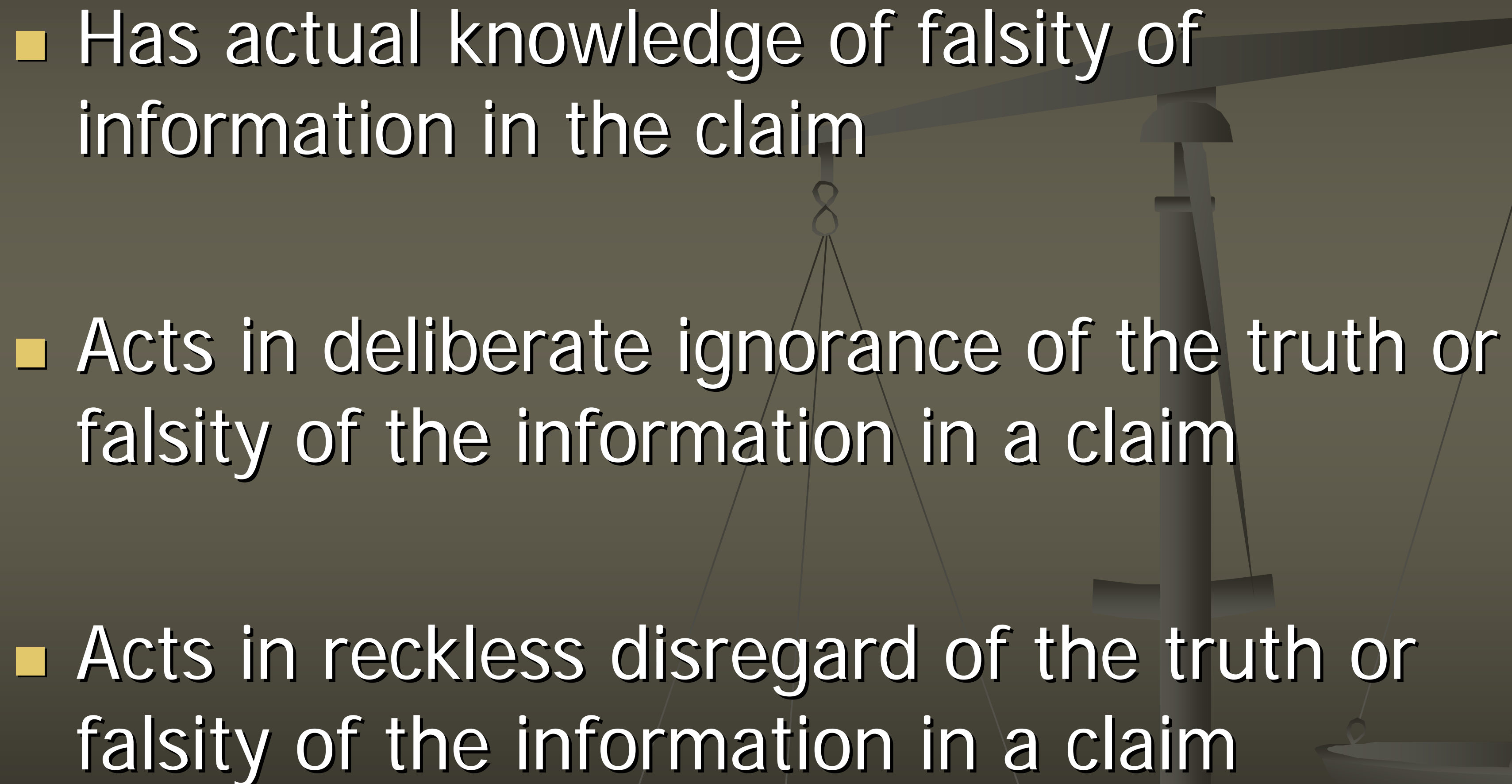


- Office of the Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- State Medicaid Fraud Control Units
- Fiscal Intermediaries/Carriers/MACs
- Medicaid Integrity Program Contractors (MICs)
- State Survey and Certification Agencies
- Office of Civil Rights (HIPAA)
- Recovery Audit Contractors (RACs)
- Healthcare Fraud Prevention and Enforcement Action Team (HEAT)

False Claims Act

- Criminal and Civil penalties
  - Fines
  - Prison
- “Knowingly make a false claim”
- Treble damages
- $5,000-$10,000 per false claim

“Knowingly” means:



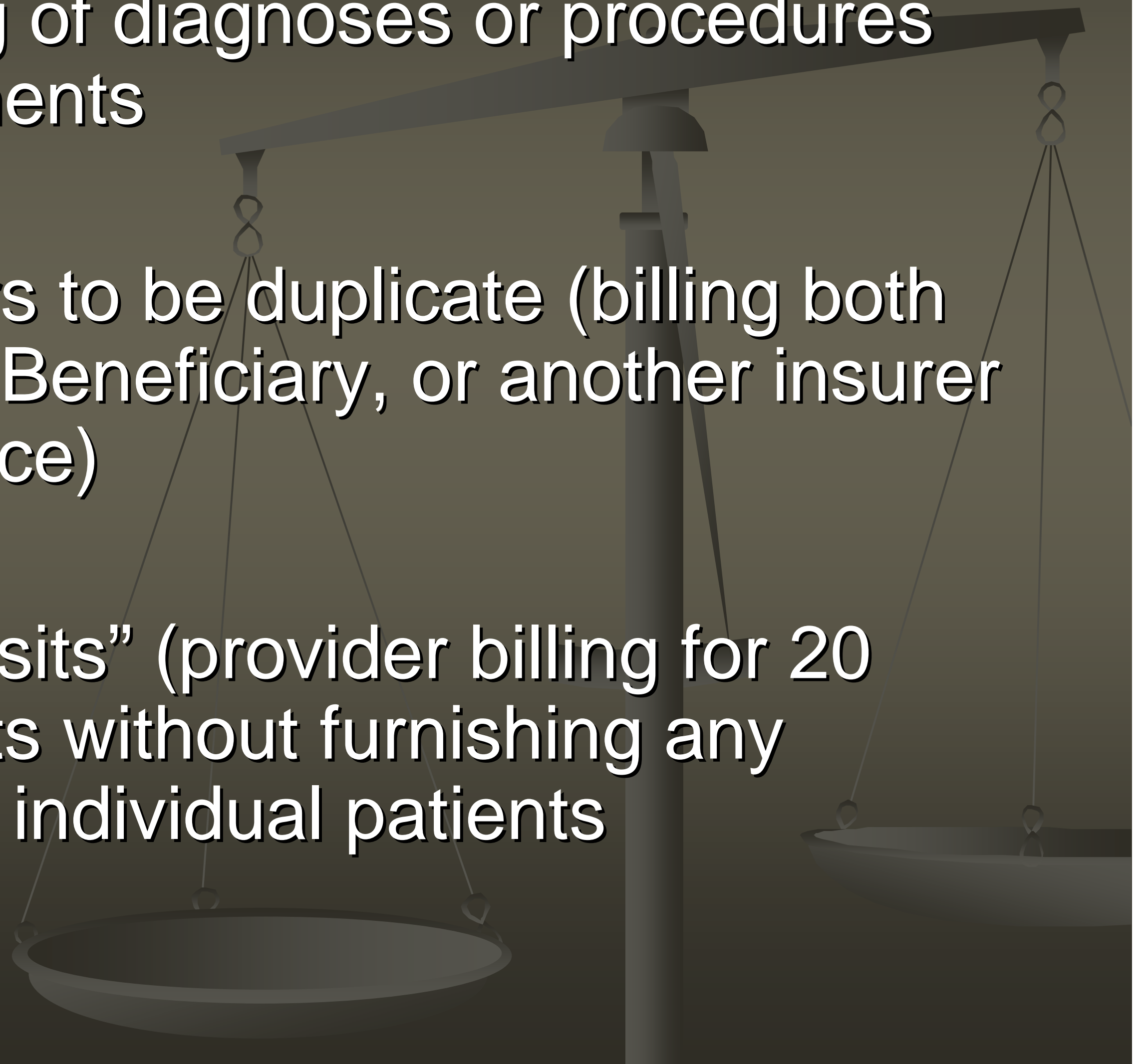
- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim
- Acts in reckless disregard of the truth or falsity of the information in a claim

Examples of Healthcare Fraud

- Billing for services not rendered (includes billing Medicare for appointments that patients failed to keep)
- Completing certificates of medical necessity for patients not personally and professionally known by the provider
- Billing separately for services that should be single service (unbundling)

Examples of Healthcare Fraud

- Incorrect reporting of diagnoses or procedures to maximize payments
- Billing that appears to be duplicate (billing both Medicare and the Beneficiary, or another insurer for the same service)
- Billing for “gang visits” (provider billing for 20 nursing home visits without furnishing any specific service to individual patients



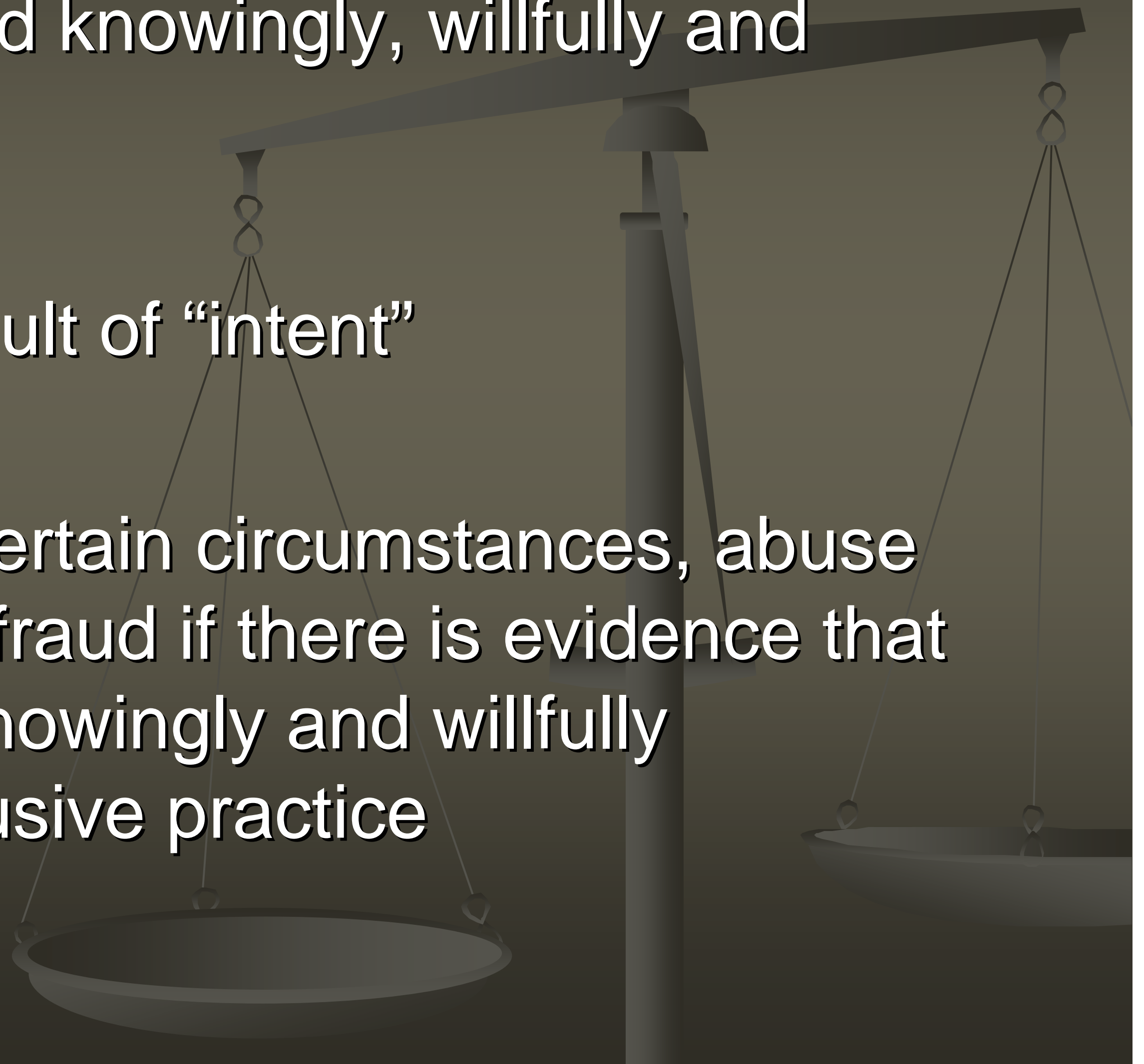
What is Abuse?

- Practices that result in unnecessary costs to Medicare, for services that fail to meet professionally recognized standards of care or services that are not medically necessary

- Payment for items or services when there is no legal entitlement and the provider has not knowingly and or intentionally misrepresented facts to obtain payment

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Routine waiver of deductibles and co-insurance
- Submitting bills to Medicare that are the responsibility of other insures under the MSP provision

Difference between Fraud and Abuse



- Fraud is committed knowingly, willfully and intentionally
- Abuse is not a result of “intent”
- However, under certain circumstances, abuse may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice

Anti-Kickback Statute

- Remuneration
  - Offering or receiving payment for referrals
  - Money, meals, trips, equipment, space
  - Direct or Indirect
- Penalties
  - Criminal Statute
  - $25,000 per violation
  - Imprisonment up to five years
  - Exclusion from Federal Healthcare Programs
  - Giver and Receiver Liable

Anti-Kickback Statute Violation Example:
Routine Waiver of Deductibles and Co-pays

- **The OIG's perspective:**

  "A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is $100, but routinely waives the copayment, the actual charge is $80. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the supplier's misrepresentation, the Medicare program is paying $16 more than it should for this item."

Source : http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html

Anti-Kickback Statute Violation Example:
Routine Waiver of Deductibles and Co-pays (cont.)

- **The OIG's perspective:**

  "At first glance, it may appear that routine waiver of copayments and deductibles helps Medicare beneficiaries. By waiving Medicare copayments and deductibles, the provider of services may claim that the beneficiary incurs no costs. In fact, this is not true. Studies have shown that if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed, rather than simply because they are free. Ultimately, if Medicare pays more for an item or service than it should, or if it pays for unnecessary items or services, there are less Medicare funds available to pay for truly needed services."

Source : http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html

Anti-Kickback Statute Violation Example:
Routine Waiver of Deductibles and Co-pays (cont.)

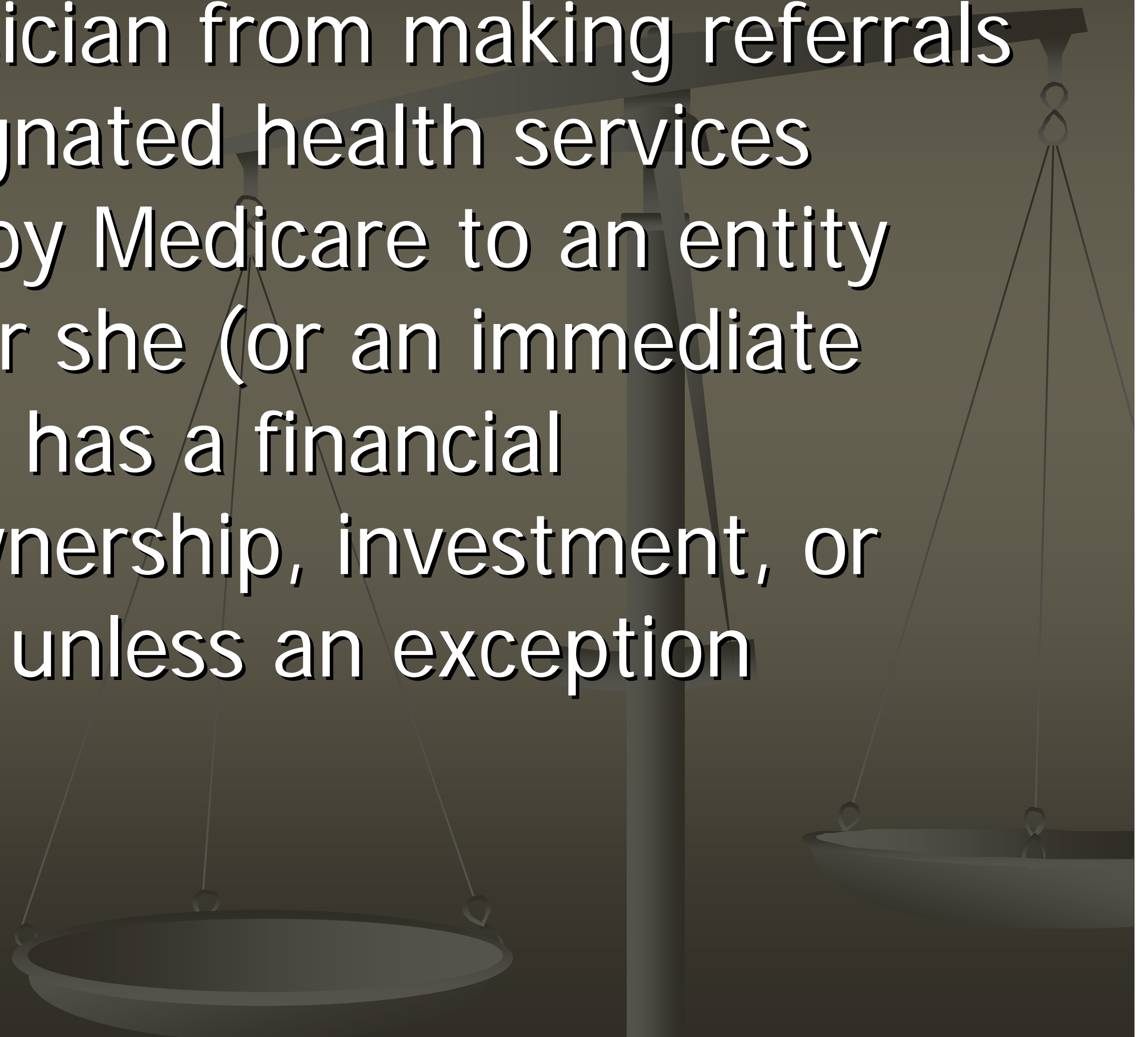
- Can providers ever waive co-pays and deductibles?

  Yes, “providers, practitioners or suppliers may forgive the co-payment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and co-payments must be made.”

Source : http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html

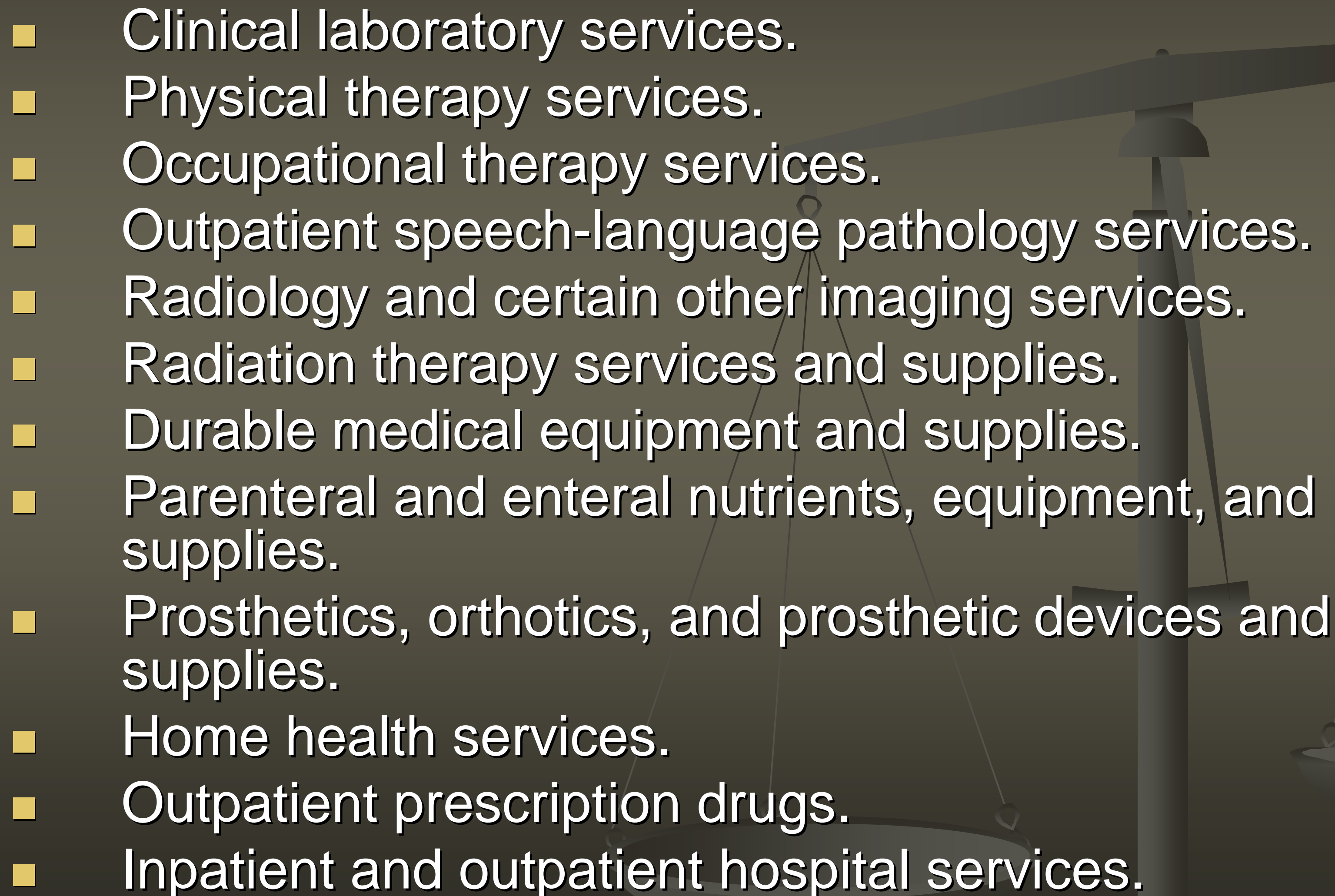
- Safe Harbors
  - Developed by the OIG to provide health care providers a mechanism to assure them that they will not be prosecuted under the anti-kickback statute for engaging in particular practices
  - May include joint ventures, managed care agreements

Stark Law



- Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.

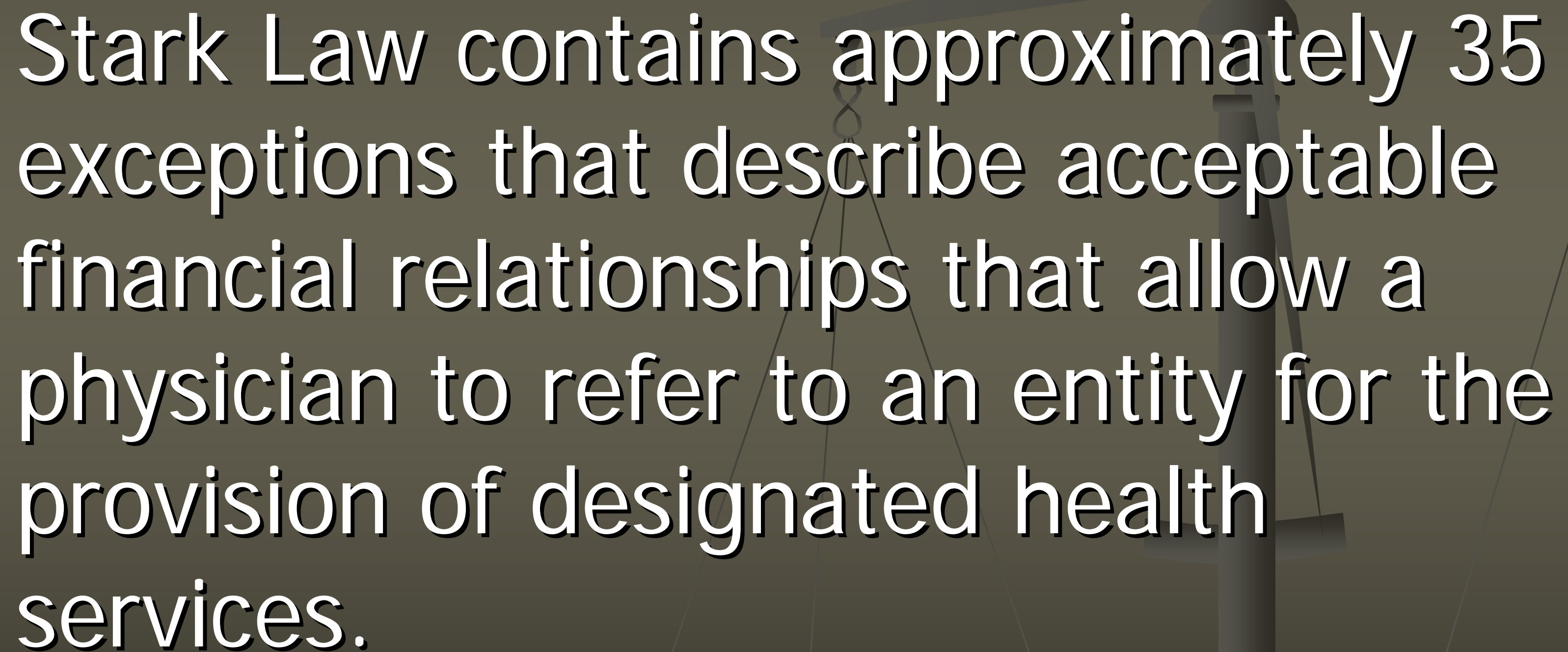
Designated Health Services under Stark Law



- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

- Civil Statute
- Violations can result in:
  - denial of payment
  - refund of payment
  - imposition of a $15,000 per service civil monetary penalty
  - imposition of a $100,000 civil monetary penalty

Stark Law Exceptions



Stark Law contains approximately 35 exceptions that describe acceptable financial relationships that allow a physician to refer to an entity for the provision of designated health services.

- *Exceptions applicable to both compensation and ownership/investment arrangements.*

- Examples of exceptions in this category include the exception for in-office ancillary services, which is perhaps the most important exception to the Stark ban, and the exception for physician services.

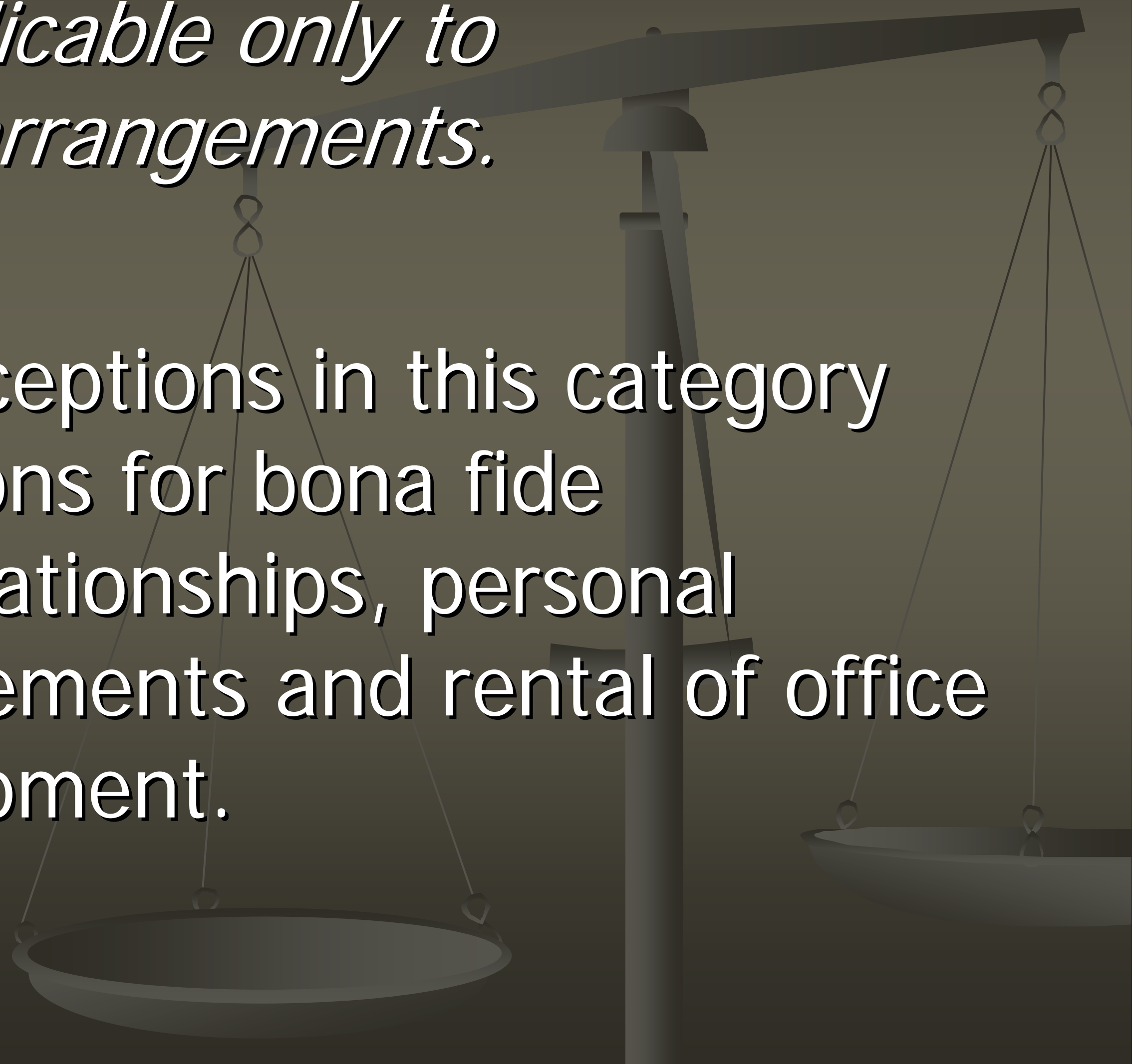
Stark Law Exceptions (cont.)

- *Exceptions applicable only to ownership or investment arrangements.*
- Examples of exceptions in this category include exceptions for publicly traded securities and mutual funds, services furnished

Stark Law Exceptions (cont.)

- *Exceptions applicable only to compensation arrangements.*

- Examples of exceptions in this category include exceptions for bona fide employment relationships, personal services arrangements and rental of office space and equipment.



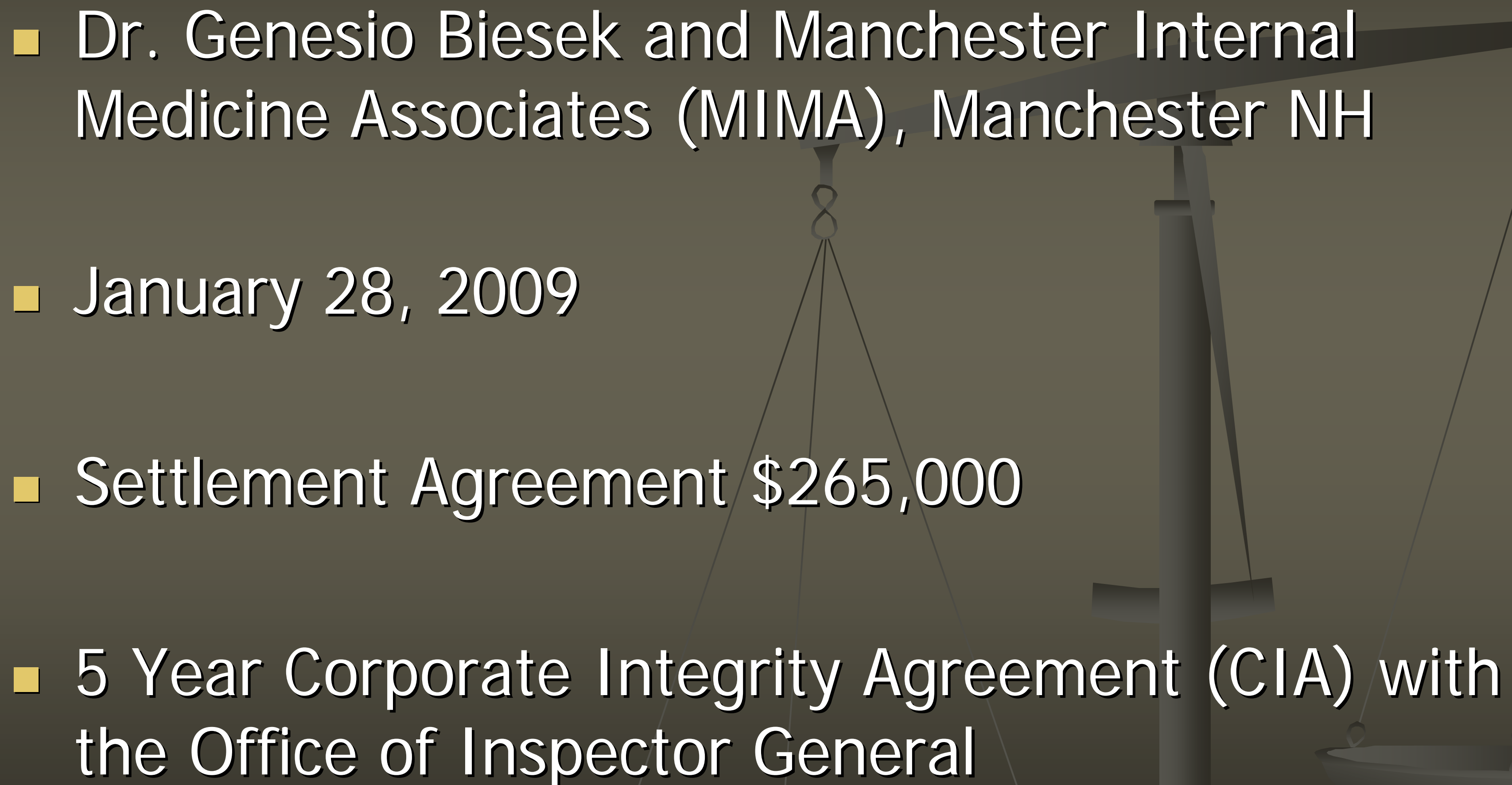
- Intended to reduce the amount of fraud, waste, and abuse in state and federal health care programs through employee education about the federal False Claims Act, state false claims acts, civil and criminal penalties.

- False Claims Act's "whistleblower" provision allows any person with actual knowledge of allegedly false claims, who has first made a good faith effort to exhaust internal reporting procedures, to file a lawsuit on behalf of the government and potentially share in a percentage of the amount recovered

- Voluntary disclosure by the provider can mitigate whistleblower lawsuits

Sample Cases

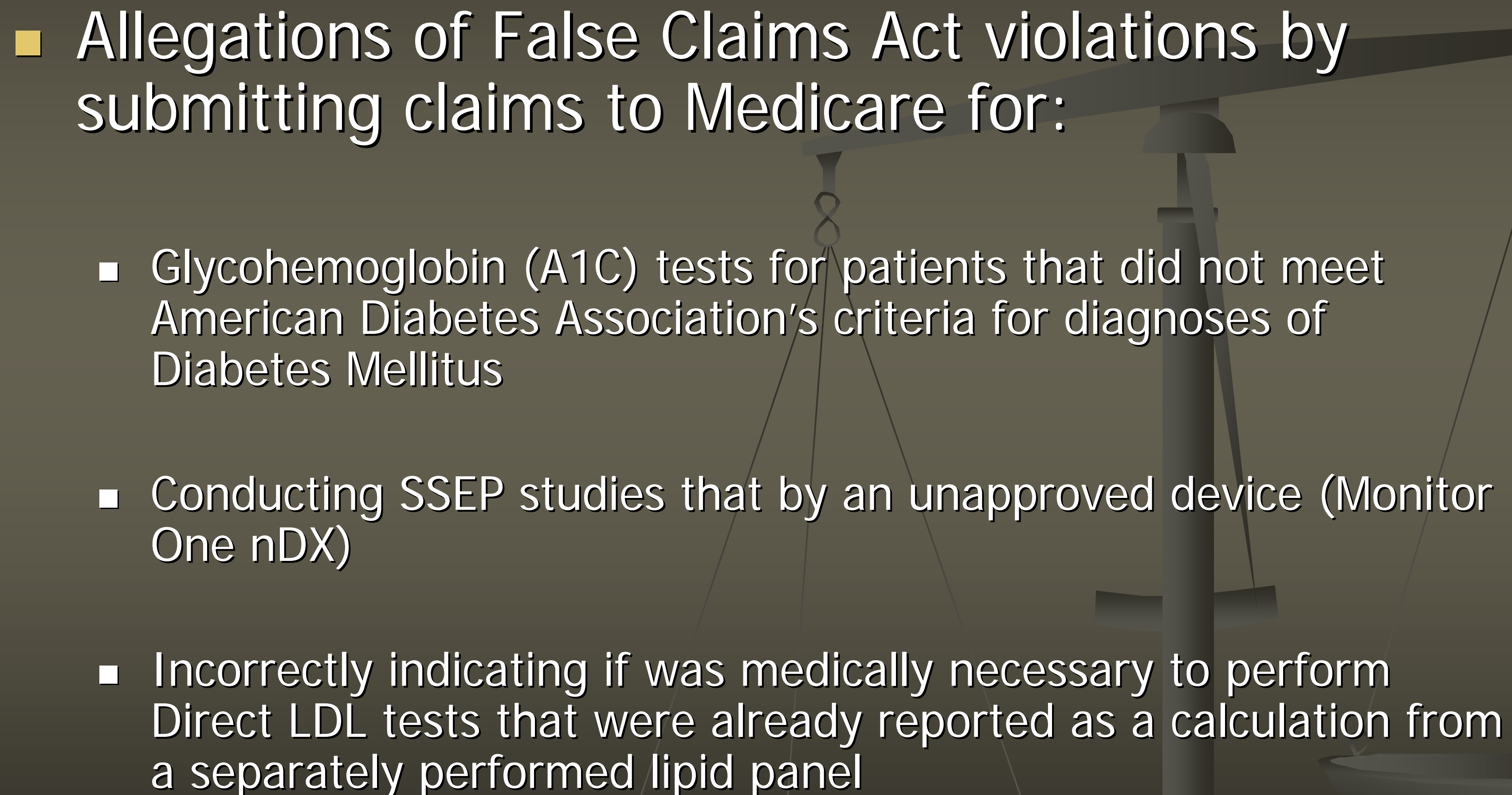
Improper Claims Submission
Manchester Internal Medicine



- Dr. Genesio Biesek and Manchester Internal Medicine Associates (MIMA), Manchester NH
- January 28, 2009
- Settlement Agreement $265,000
- 5 Year Corporate Integrity Agreement (CIA) with the Office of Inspector General

Improper Claims Submission

Manchester Internal Medicine

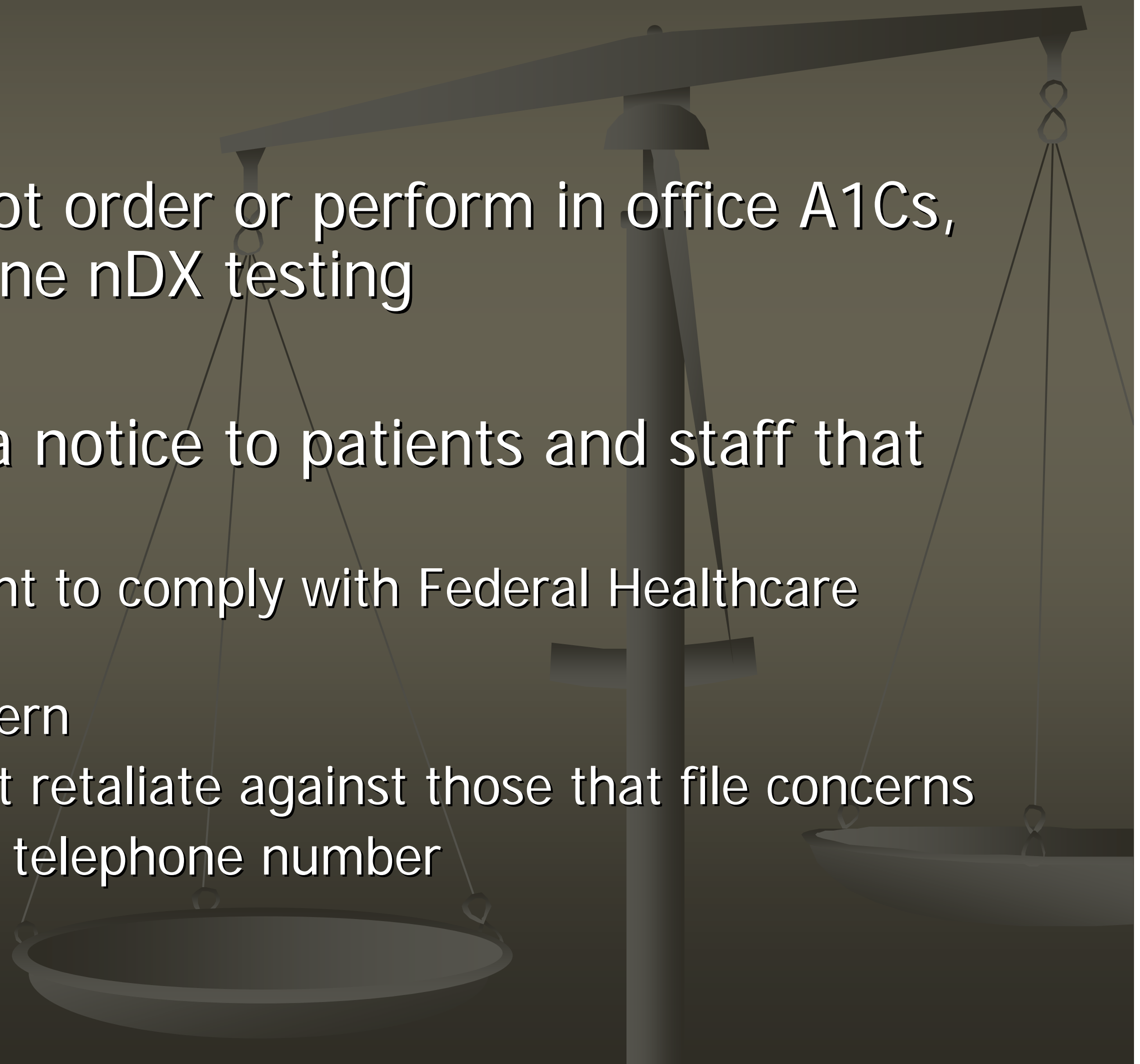


- Allegations of False Claims Act violations by submitting claims to Medicare for:
  - Glycohemoglobin (A1C) tests for patients that did not meet American Diabetes Association's criteria for diagnoses of Diabetes Mellitus
  - Conducting SSEP studies that by an unapproved device (Monitor One nDX)
  - Incorrectly indicating if was medically necessary to perform Direct LDL tests that were already reported as a calculation from a separately performed lipid panel

Improper Claims Submission

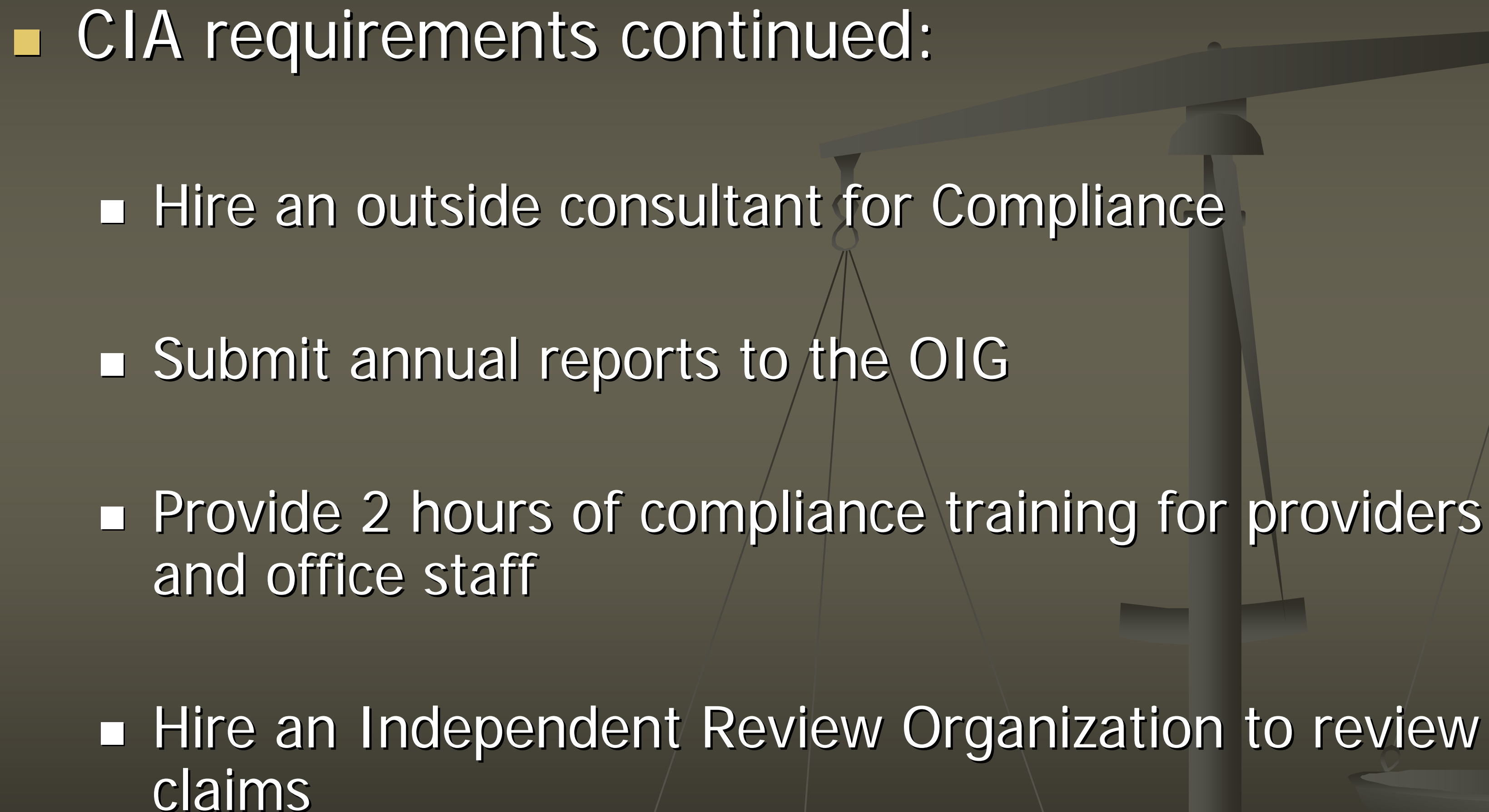
Manchester Internal Medicine

- CIA requirements:
  - The practice cannot order or perform in office A1Cs, LDLs or Monitor One nDX testing
  - Prominently post a notice to patients and staff that includes:
    - MIMAs commitment to comply with Federal Healthcare programs
    - How to file a concern
    - That MIMA will not retaliate against those that file concerns
    - OIG Fraud Hotline telephone number



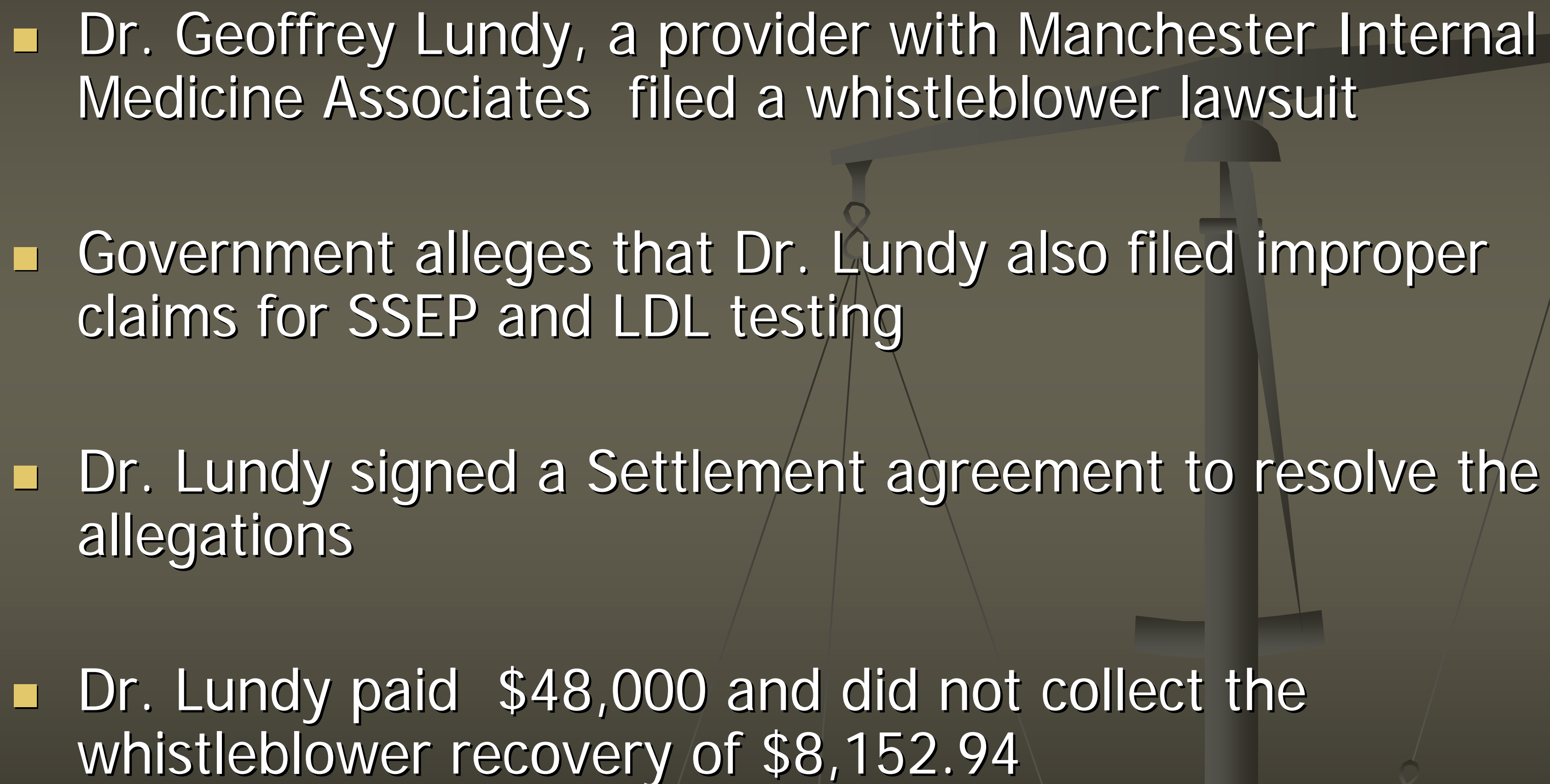
Improper Claims Submission
Manchester Internal Medicine

- CIA requirements continued:
  - Hire an outside consultant for Compliance
  - Submit annual reports to the OIG
  - Provide 2 hours of compliance training for providers and office staff
  - Hire an Independent Review Organization to review claims



Improper Claims Submission

Manchester Internal Medicine



- Dr. Geoffrey Lundy, a provider with Manchester Internal Medicine Associates filed a whistleblower lawsuit
- Government alleges that Dr. Lundy also filed improper claims for SSEP and LDL testing
- Dr. Lundy signed a Settlement agreement to resolve the allegations
- Dr. Lundy paid $48,000 and did not collect the whistleblower recovery of $8,152.94

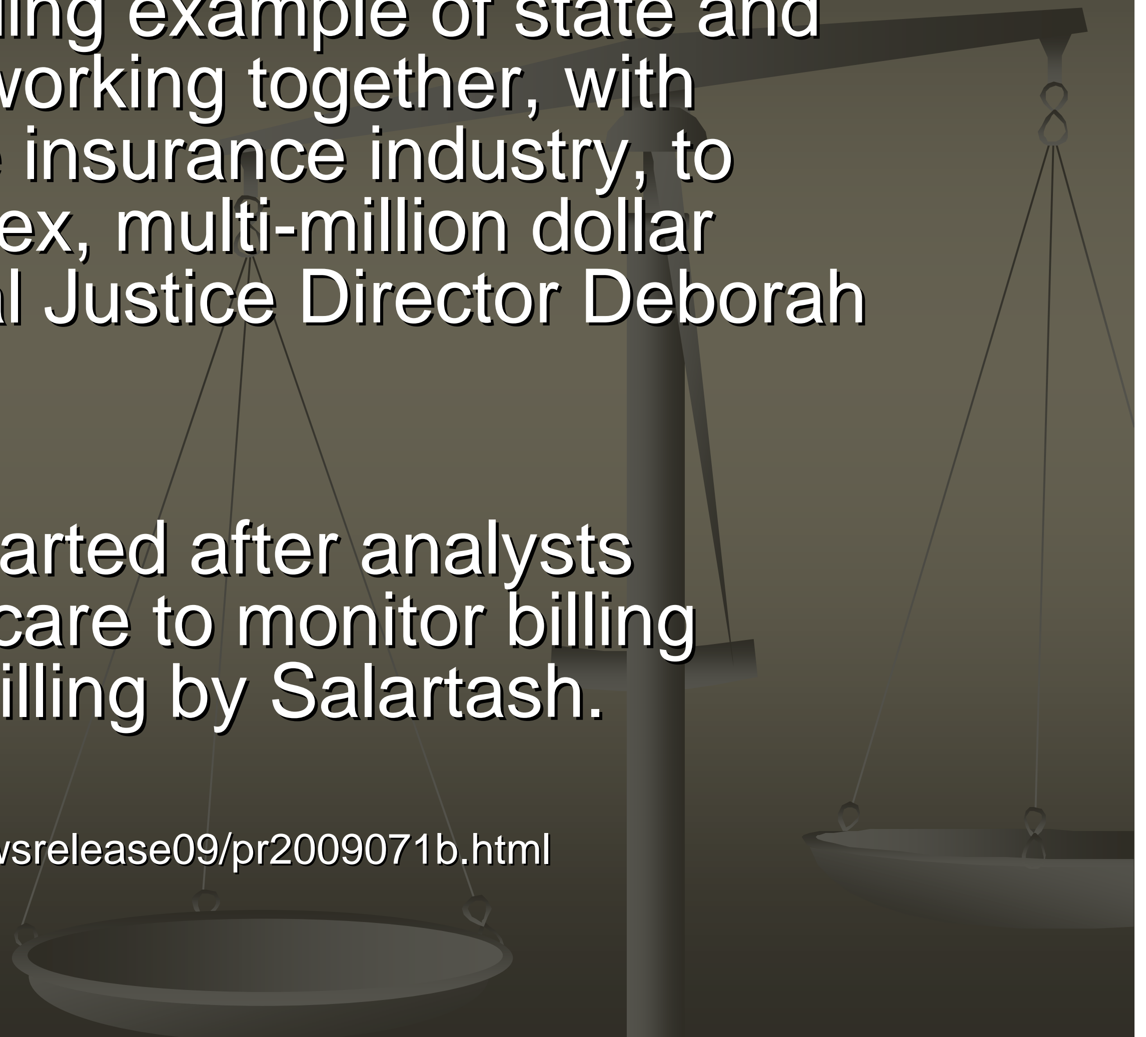
- **Florida July 17, 2009**
  - **$1.7 Million Settlement**
  - **Government seized five vehicles and $976,000 that Dr. DeCandido transferred to his wife**
- **False Claims Act**
  - **billing Medicare for higher levels of service than rendered**
  - **billing for services not rendered**
- **Whistleblower lawsuit**

- Sourcehttp://www.justice.gov/opa/pr/2009/July/09-civ-693.html

Improper Claims Submission
Dr. Khashayar Salartash

- **July 13, 2009 in Egg Harbor Township, New Jersey**
- **Grand Jury Indictment for misrepresenting services and defrauding Medicare, Medicaid and private insurance companies out of $85 million**
- **Horizon Blue Cross Blue Shield filed $1.8 million suit**
- **Submitted claims stating that Dr. Salartash had provided the services when in fact a physical therapist, LPN or massage therapist performed the service with no supervision**
- **Source: http://www.nj.gov/oag/newsrelease09/pr2009071b.html**

Improper Claims Submission
Dr. Khashayar Salartash

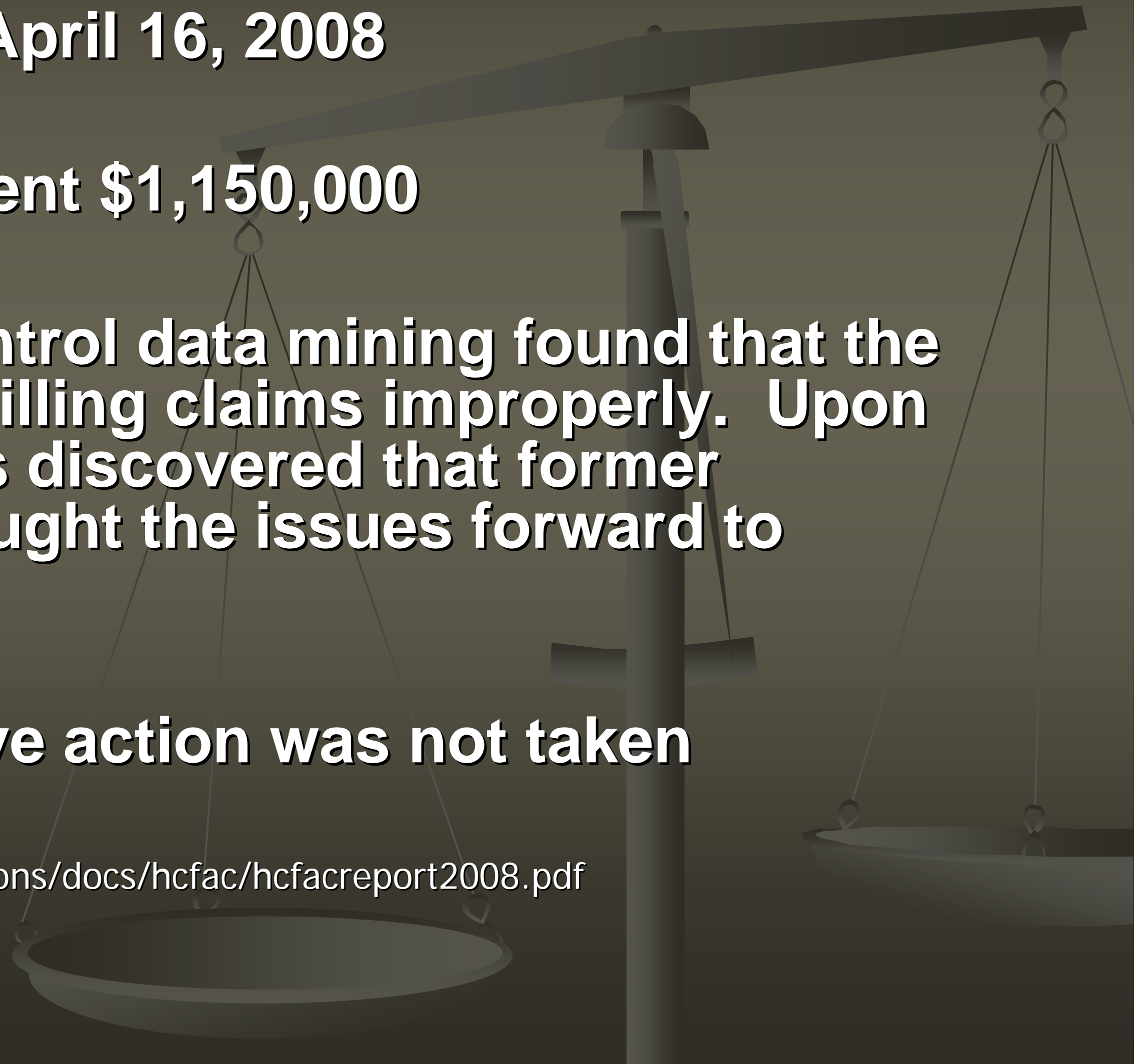


- "This is an outstanding example of state and federal authorities working together, with assistance from the insurance industry, to investigate a complex, multi-million dollar fraud," said Criminal Justice Director Deborah L. Gramiccioni.

- The investigation started after analysts contracted by Medicare to monitor billing identified unusual billing by Salartash.

- Source: http://www.nj.gov/oag/newsrelease09/pr2009071b.html

Improper Claims Submission
Henrietta Goodall Hospital

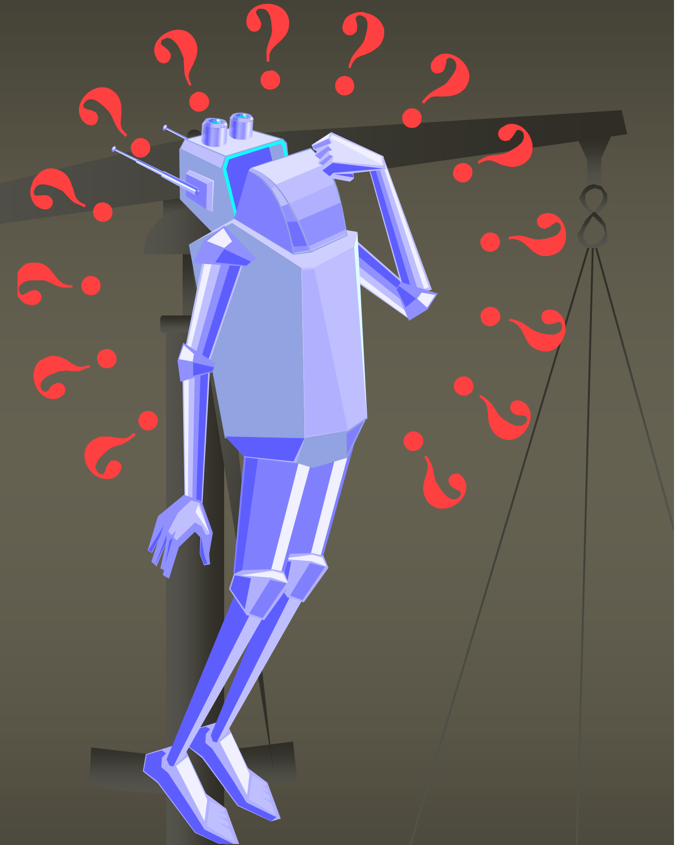


- **Sanford, Maine on April 16, 2008**
- **Settlement Agreement $1,150,000**
- **Medicare Fraud Control data mining found that the hospital has been billing claims improperly. Upon investigation, it was discovered that former employees had brought the issues forward to management.**
- **Necessary corrective action was not taken**
- Source: http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2008.pdf

Steps to Minimize Risk

The Three "C"

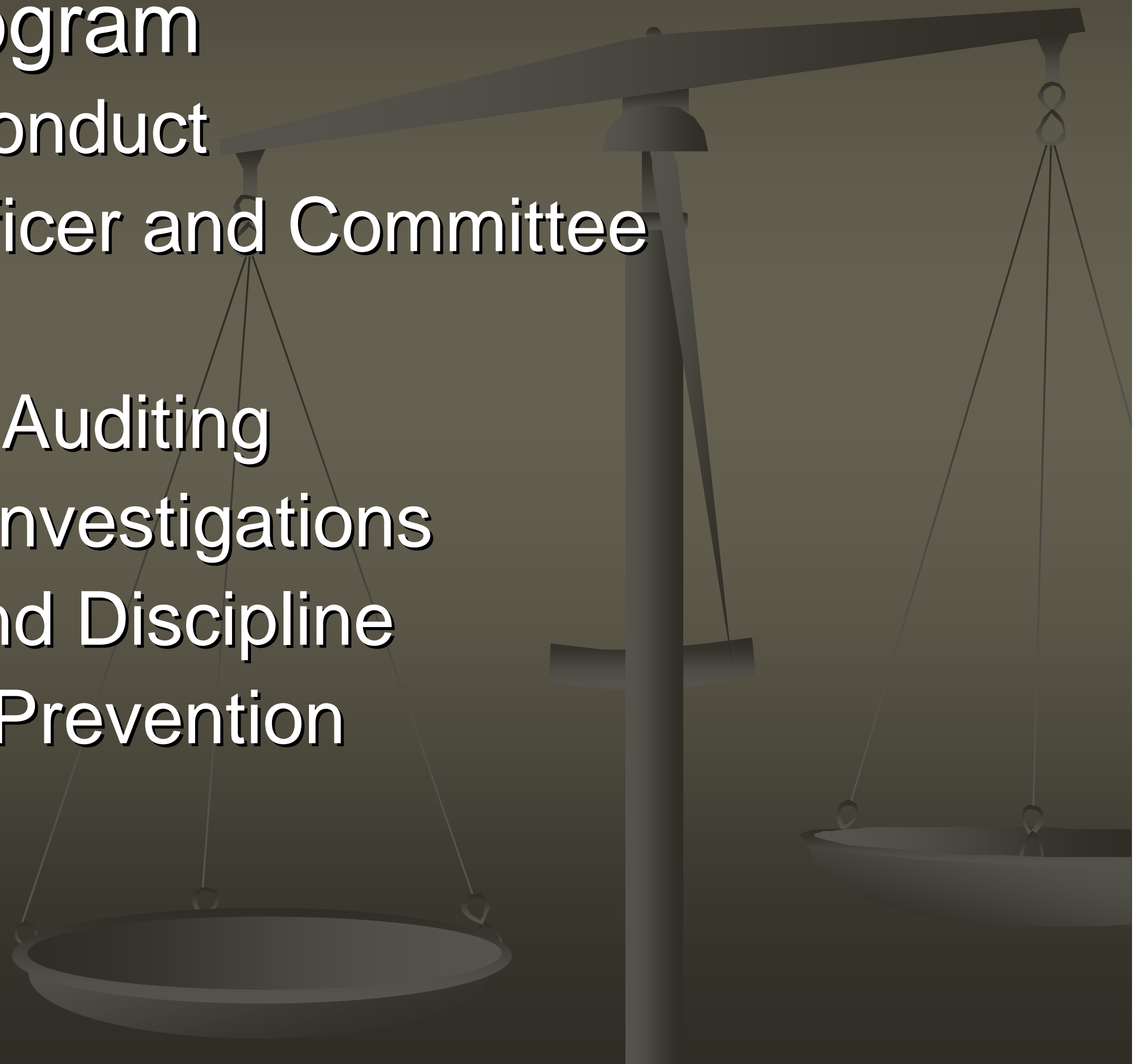
Things to ponder when making a decision



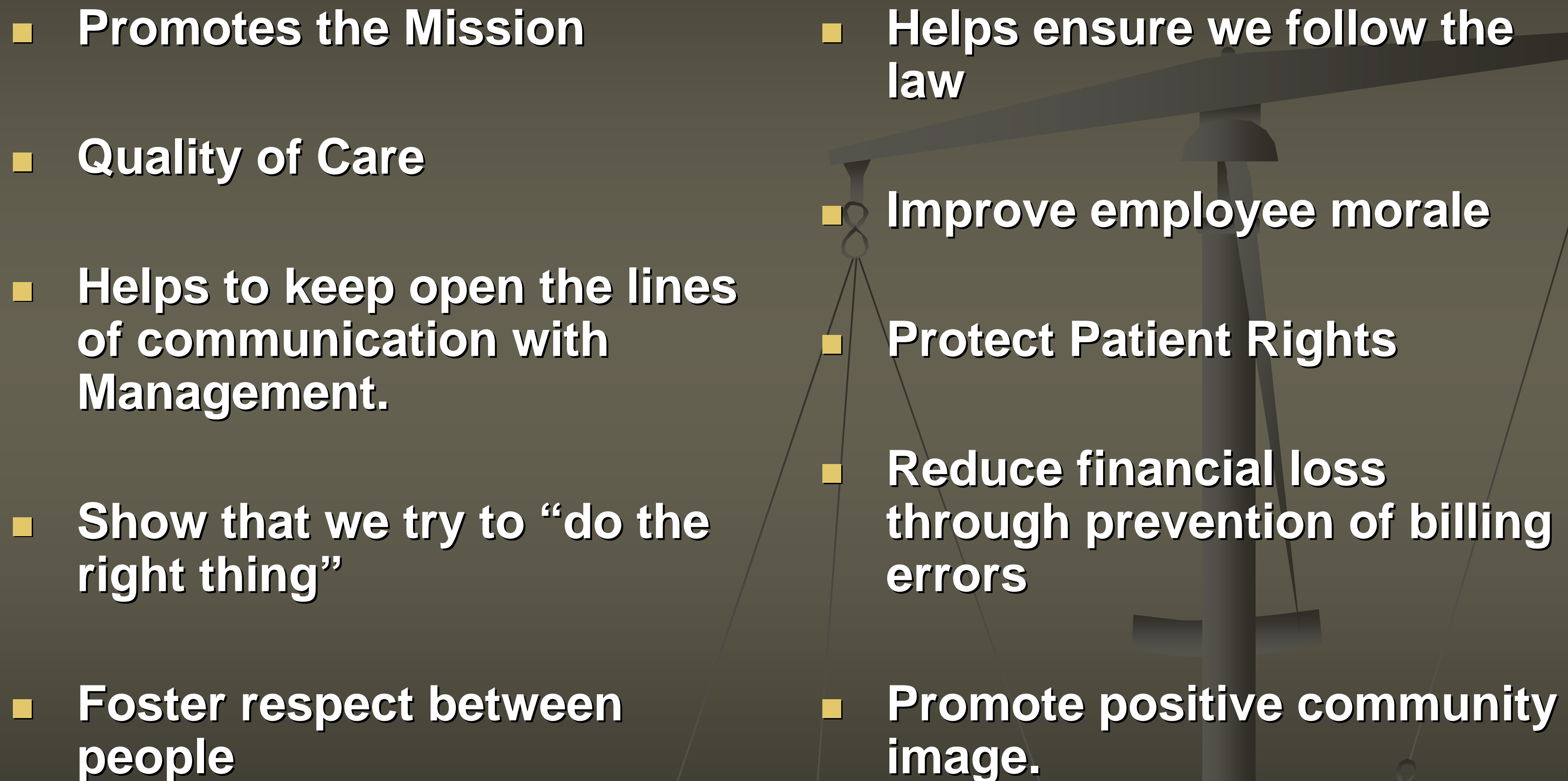
- **Compliance**
  - **Does the situation involve the violation of a law?**
- **Conscience**
  - **Does the situation involve a violation of an ethical principle?**
- **Conduct**
  - **Assess your alternatives for addressing the situation and decide on a course of action which will resolve the situation in a timely manner.**

OIG Compliance Guidance

- Compliance Program
  - Standards of Conduct
  - Compliance Officer and Committee
  - Education
  - Monitoring and Auditing
  - Reporting and Investigations
  - Enforcement and Discipline
  - Response and Prevention



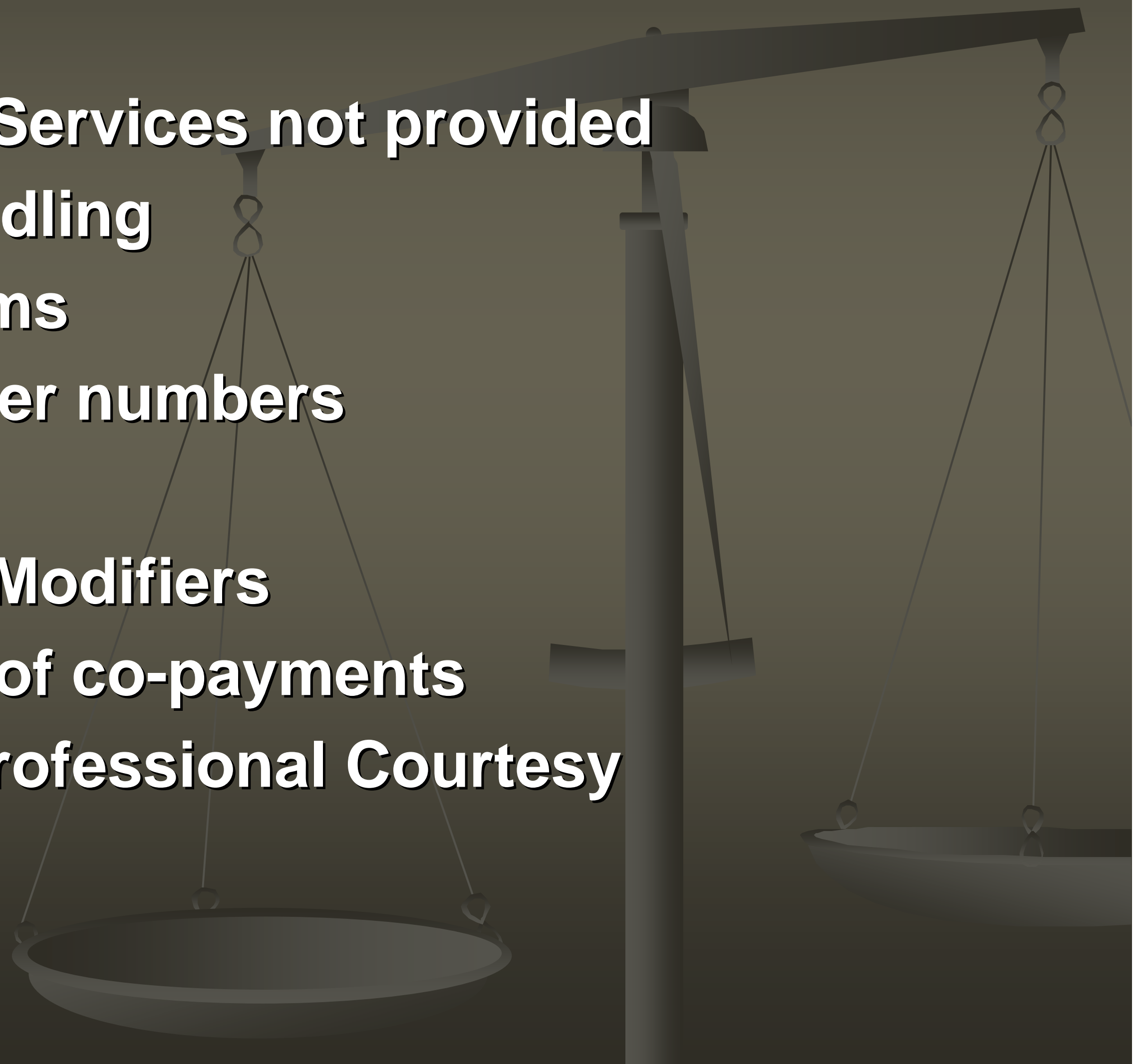
Why have a Compliance Plan?



- Promotes the Mission
- Quality of Care
- Helps to keep open the lines of communication with Management.
- Show that we try to “do the right thing”
- Foster respect between people
- Helps ensure we follow the law
- Improve employee morale
- Protect Patient Rights
- Reduce financial loss through prevention of billing errors
- Promote positive community image.

OIG Compliance Guidance
for Physicians

- Risk Areas:
  - **Billing for Items/Services not provided**
  - **Upcoding/Unbundling**
  - **Computer Systems**
  - **Misuse of Provider numbers**
  - **Duplicate Billing**
  - **Improper use of Modifiers**
  - **Routine waivers of co-payments**
  - **Discounts and Professional Courtesy**



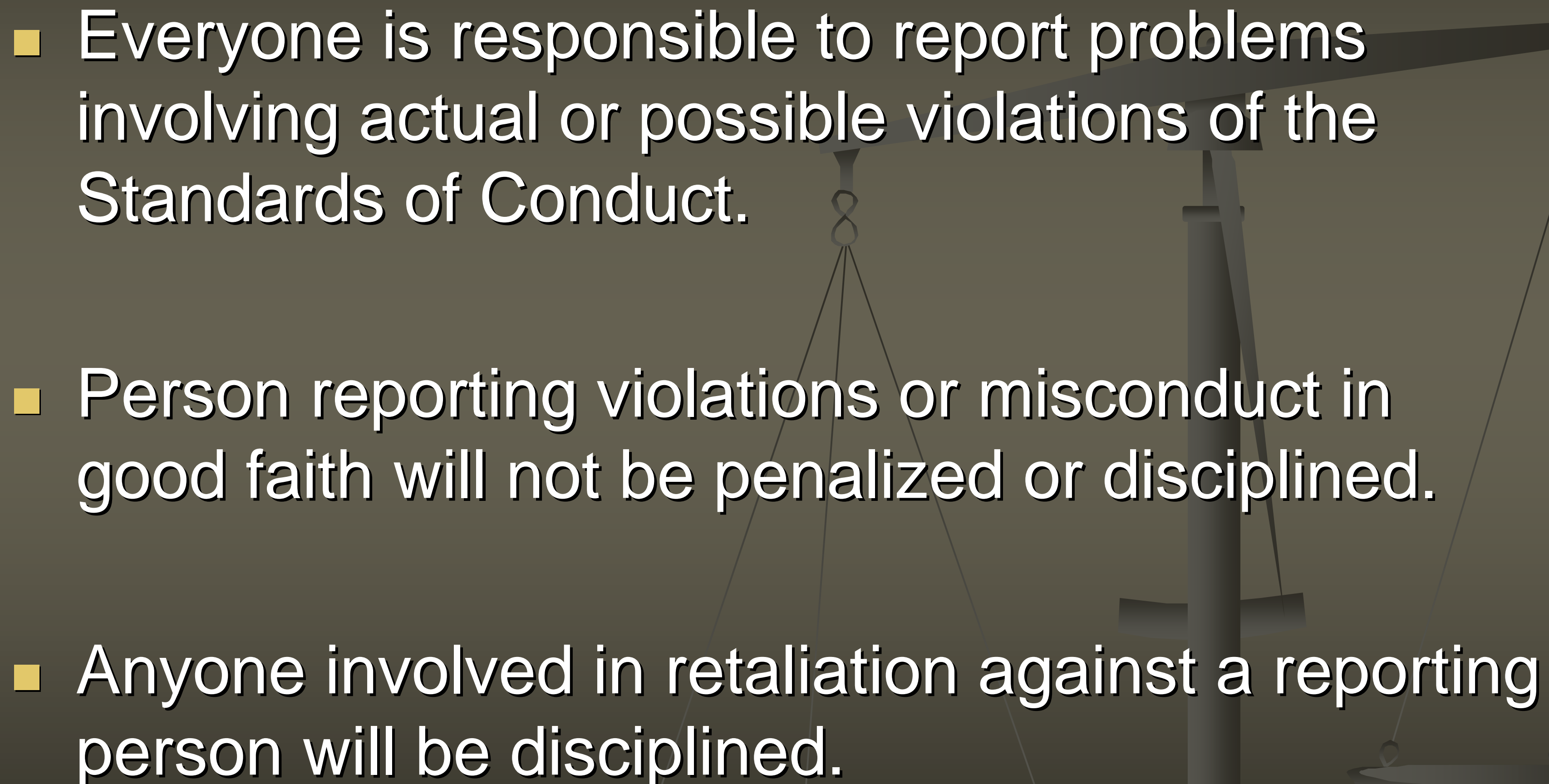
Compliance Program

Standards of Conduct

at St. Joseph

- Quality of Care
- Compliance with Laws and Regulations
- Billing and Coding
- Conflict of Interest
- Human Resources
- Environment of Care
- Safeguarding Resources and Assets
- Communications

Non-retaliation & Problem Reporting Policy



- Everyone is responsible to report problems involving actual or possible violations of the Standards of Conduct.
- Person reporting violations or misconduct in good faith will not be penalized or disciplined.
- Anyone involved in retaliation against a reporting person will be disciplined.

Report To:

- Supervisor, Manager or Director
- Human Resources
- O.I. Coordinators
  - Paula Christy, Hospital
  - Extension 63107
  - Janice Bosteels, Corporate
  - Extension 63824
- O.I. Officer (Covenant)
  - Ken Ferron 1-781-862-5477
- Help Line - 1-877-631-0013

*For quality of care issues, employees may also notify The Joint Commission:
E-mail: complaint@jcaho.org
Fax: 1-630-792-5636