Fraud And Abuse Compliance

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What Exactly is the Goal

- Ensure that all care rendered:
  - is medically necessary
  - is properly documented

- Ensure that all care billed for reimbursement:
  - was rendered in line with preferred practice patterns and accepted clinical guidelines
  - was provided with no outside influence on the provider's determination of medical necessity or recommended treatment

Disclaimer

I am not an attorney and do not provide legal advice. If you want legal opinions, melt all your scrap gold down and find a good health care attorney.

Summarized...

It's all about doing what is right for the patient, the right way, without any influence from real or perceived monetary gain

Background – Fraud and Abuse

- 2000 – HHS recommends VOLUNTARY fraud and abuse training for all providers
- 2010 - Patient Protection and Affordable Care Act (ultimate oxymoron) made the F/A programs mandatory for any Medicare or Medicaid payer and any provider billing Medicare or Medicaid. Only released guidelines for payer participation
- 2014 – CMS released compliance program guidelines for small providers (lul)

And doctors aren’t doing that?

2012 estimates of loss from fraud and abuse in the Medicare system alone

$65 BILLION guess they aren’t...
Big Deal?

You kidding???
Big enough deal / concern that fraud and abuse in health care appears in 37 of the 111 agenda items on the Office of the Inspector General’s 2014 Work Plan

2015 OIG Plan

- Excessive nursing home care services
- Non-compliance with CLIA
- Contractor performance issues (what?)
- Reducing costs for DME
- Recovering Medicaid overpayments
- Increasing Medicaid Fraud Control Units
- Increase Senior Medicare Patrol projects

AND....

Increase investigation of ophthalmologists for “inappropriate and questionable billing practices”

Don’t get excited...we use the same codes and that is what they are looking at!

2015 Plan Just Released

- 77...count them...77 health care items
- Fraud and abuse cited by the OIG as THE number one concern in health care today
- Listening? Not the uninsured, not the ACA, not Medicaid expansion...
  **IT IS DOCTORS, INCLUDING OPTOMETRISTS, ABUSING HEALTH CARE REIMBURSEMENT**!

Convinced this is not a big deal?

Think it doesn't apply to you???
If you think improper coding or inadequate medical records documentation is just being lazy or worst case scenario you pay a few bucks back
If you think running full glaucoma evaluations every six months on Ms. Jones simply because her aunt has glaucoma
If you think a specular microscopy evaluation of a patient with a superficial corneal foreign body is medically necessary

If you think referring a patient to a retinal specialist just because they are diabetic is “good care”
If you think “screening” your exam room for children with Medicaid to get them back for exams that day is legal (“unsolicited personal contact”)
If you think getting your CE free from the center where you refer your cataract patients is “OK”

Then you will NOT like the new world of fraud and abuse scrutiny!

Fraud
Knowing and willingly executing a scheme to defraud any health care benefit program

Abuse
Actions involving medically UN-necessary claims resulting in increased costs to the health care system

Waste
Over-utilization of services that result in unnecessary costs to the health care system

Waste does NOT involve criminal or negligent actions

The lines between fraud and abuse are now VERY blurred – historically it was “intent” (fraud) vs “I didn’t know!” (abuse). But the law now says you are legally bound TO KNOW! Where does that leave abuse?

Five Main Fraud and Abuse Laws
- False Claims Act
- Anti-Kickback Statute
- Provider Self-Referral Law
- Exclusion Statute
- Civil Monetary Penalties Law

ABSOLUTELY NOT!
From what we see going on in OPTOMETRY all across the country - some of your colleagues could end up in these pictures

Really Joe... isn’t this a bit over the top?

Absolutely not!
**False Claims Act (FCA)**

**SUMMARY**
A Provider cannot submit claims for payment that they know or should know are false, fraudulent or not medically necessary.

**Fines include three times the program’s loss plus fines of $11,000.00 per claim**
**You have 60 days from notification or self-realization of the overpayment to refund money that doesn’t belong to you (oooo….what exactly does that mean?)**
**Prompt refunds typically do not result in fines but failure to refund can carry the additional $11,000.00 fine per claim**

**“Should know” - liberally interpreted and includes “reckless disregard for the truth”**
**FCA does NOT apply to billing “errors” but makes it clear providers are expected to know the rules – especially the concepts of reason for the visit, medical necessity and proper medical records documentation**
**Not knowing equates with guilty under FCA**

**Anti-Kickback Statute (AKS)**

**SUMMARY**
Prohibits the knowing and willful acceptance of any remuneration as an intentional or unintentional inducement to reward patient referrals for services that may be paid for by federal funds.

**This law has a great deal of ambiguity but is translated VERY liberally**
**Remuneration is defined as:**
- ANYTHING of value including money, free services, meals, excessive consultation fees or provision of CE leading to education credits for which you did not pay a reasonable fee.
- **Government does not have to prove harm. The simple implication of inducement is deemed as guilty.**
AKS also applies to routine waiver of copays and deductibles – both being illegal if used incorrectly

“Same day discounts” are allowable but only if the resultant discounted fee is not less than the Medicare allowable fee

Other discounts or even free services are allowed for charitable or indigent care as well as professional discounts (be very careful here)

“Inducement” penalties apply equally to the individual providing the inducement AND the individual responding to it (again, intentional or unintentional!)

Providers are a huge target for AKS fines due to the constant need to inter and intra-referral of patients

Penalties include fines up to $50,000.00, jail time and/or exclusion from all Federal payer systems (Medicare and Medicaid)

Designated services include:
- Radiation therapy and radiation services
- Radiology and certain imaging services
- Clinical laboratory services
- Physical, occupational and language therapy
- Home health services
- DME, prosthetics and orthotics
- Parenteral and enteral nutrients
- Inpatient and outpatient hospital services
- Outpatient prescription drugs

Government does NOT have to prove the referral was made for financial gain – implication is all it takes

There are “safe harbors” for certain relationships and arrangements but they are very complex and should not be entered into without legal consultation

Financial penalties are very severe in addition to criminal convictions and exclusion from federal payer programs

By law, the Government restricts providers convicted of certain crimes or behaviors from participating in any federal payer program
Main “exclusion” offenses include:
- Medicare or Medicaid fraud
- Patient abuse or neglect
- Felony convictions or other health care fraud
- Felony conviction for unlawful manufacture, distribution or prescribing of controlled substances
- There are many other lessor offenses they can act on if they wish

There are many other lessor offenses they can act on if they wish.

Providers may NOT contract with or employ another provider who has been excluded from Medicare or Medicaid if there is any chance their services could be billed to Medicare or Medicaid. The exclusion list can be found at: www.oig.hhs.gov

Potential CMPL violations:
- Violating conditions of a payer contract
- Making false statements when applying for inclusion in a payer program
- Failure to provide proper emergency care to a patient
- Penalties include fines from $10-50,000 per violation and can be levied on top of other penalties under FCA, AKS, etc.

Other than the doctor/patient relationship, ethical behavior of providers is organized around:
- Relationships with payers
- Relationships with fellow providers
- Relationships with vendors

Civil Monetary Penalties Law (CMPL)

Relationships with patients is increasingly dominated by a third party – the payer

Components of the provider/payer relationship include:
- Accurate coding and billing
- Accurate medical records documentation
- Prescription authority
- Assignment within the Medicare system
The main issues involved in billing for rendered services include:

- Billing only:
  - medical necessity care
  - services actually performed
- Billing for:
  - services with no benefit or beneficial outcome ("worthless")
  - services provided by improperly trained or improperly supervised individuals
  - services provided by a provider listed in the Federal Exclusion Statute list

The OIG is VERY serious about "worthless" services – patient services that provide no real diagnostic or therapeutic benefit to the patient. The last three convictions in 2014 all resulted in CRIMINAL convictions with federal prison sentences up to 10 years.

"In submitting this claim for payment from federal funds, I certify that 1) the information on this form is true, accurate and complete 2) I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor 3) I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision 4) this claim complies with all Medicare program instructions and…" lists all five Federal compliance laws.

Special Note!
The OIG is very serious about "worthless" services – patient services that provide no real diagnostic or therapeutic benefit to the patient. The last three convictions in 2014 all resulted in CRIMINAL convictions with federal prison sentences up to 10 years.

And...
"My signature is to certify that the foregoing information is true and accurate. I understand that any false claims or statements or concealment of a material fact may be prosecuted under applicable Federal and Stark laws.”

GOOD LUCK TRYING TO SAY YOU DIDN’T KNOW BETTER!

Relationship With Payers
Accurate Billing and Coding

By contract with the payer, providers attest that the patient’s medical records are:
- Accurate
- Complete
- Show justification of medical necessity

Read the back of your HCFA1500 form some day. It is a LEGAL CONTRACT assuring the necessity and truthfulness of your services.

Relationship With Payers
Medical Records Documentation

Relationship With Payers
Prescription Authority

Providers with prescriptive authority
must remain in compliance with federal
and state controlled substance laws
(DEA, state programs, scope of care)

This issue is so significant that violations
can result in exclusion from all federal
payer programs.
Participating Medicare providers must accept only the Medicare allowable fee for covered services.

Non-participating Medicare providers are not bound by the Medicare Assignment Rule but cannot charge patients more than the Medicare limiting fee.

Providers conducting a concierge or retainer practice may not charge a Medicare patient an access or administrative fee.

Referral decisions cannot be influenced in any way based on personal gain to the referring provider.

Refer back to section on Provider Self-Referral Law.

These decisions are complex and often require legal counsel.

It is perfectly legal for a pharmaceutical company to provide free samples – it is totally illegal for a provider to sell those samples to a patient.

Although arguably excessive, the Pharm Laws significantly limit the interaction between providers and medicine suppliers.

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How To Make It Happen

- All practices must have:
  - written compliance manuals
  - documented evidence that their staff has been trained on compliance issues
- Providers can develop this material themselves or partner with compliance companies to produce them

Compliance Standards

- HIPAA risk analysis should be contained in Security Manual
- Hazard risk analysis should be contained in Hazard Manual
- Fraud/abuse and coding/documentation risk analysis
  - Initial billing and documentation audit
  - Follow up audits on an as needed basis

Compliance Training

- No standard format
  - Significant “flexibility of approach” based on individual practice needs
- No standard content
  - Recommended topics include HIPAA, Hazard, Fraud and Abuse, Coding and Documentation (doctors and selected staff)
- No standard timing
  - OIG recommends upon initial hire then consider annual updates
- Outside training and education
  - Might be good idea but usually would not substitute for in-office training program - not specific to individual office policies

Compliance Training Goals

- Each provider and staff will:
  - have complete knowledge of how compliance issues effect the performance of their job
- Each doctor and staff will:
  - understand that compliance is a condition of continued employment

Correcting Offenses

- Investigating alleged and confirmed compliance offenses is the most important part of a compliance program
- The Compliance Officer is charged with overall monitoring of the practice’s compliance program but input from any doctor or staff is encouraged
Internal/external audit results
Concerns/allegations of providers or staff
Outside Whistleblowers
Compliance Officer concerns based on:
- Changes in number of type of claims rejections
- Unusual changes in or application of CPT or ICD
- Unexplained increase in procedure usage
- Letters from carriers / payers questioning billings or requesting review of medical records

The practice should adopt a “zero tolerance” policy as it relates to compliance with fraud and abuse laws. A provider or employee who knowingly and with reckless indifference violates practice’s Compliance Policy should be terminated. A provider or employee who unknowingly or abusively violates practice’s Compliance Policy should be investigated by the Compliance Officer and dealt with based on the severity of the offense. At a minimum, additional education and training should be required.

Small practices need lines of communication between providers, employees, and the Compliance Officer that are open enough to allow for effective means of relaying information regarding potential fraud or abuse.
Small practices are still obligated to inform providers/employees they can anonymously communicate directly to the OIG.
  - OIG Web Hotline: http://oig.hhs.gov/fraud/hotline
  - OIG Phone Hotline: 1-800-447-8477

After a thorough investigation of the concern and a determination of violation has occurred, the Compliance Officer should take one of the following steps:
  - For perceived minor violation:
    - report the violation using the OIG Self-Reporting Tool at http://oig.hhs.gov/fraud/selfdisclosure.asp
  - For more significant violations:
    - contact legal counsel and follow their advice
  - For known fraudulent activity:
    - report directly to the OIG Hotline (phone or web)

Health care is changing… let us help you keep up

THANK YOU