Fraud and Abuse

Current Trends and Enforcement Activities

KOHLER
HEALTHCARE CONSULTING INC
Putting the pieces together

Agenda

- Background
- Overview of Key Fraud and Abuse Laws
- Enforcement
- Recent Significant Cases and Trends
- Areas of Focus and Challenges for 2014
- Identifying your Risk Areas
- Strategies for Focusing Resources

Background

- Health care Reform Increased Fraud Enforcement Activities. Fraud recoveries planned to help fund Reform.

- Fraud Recoveries for 2013 were 4.3 Billion, 19.2 over past 5 years

- 849 criminal prosecutions in 2013-Medicare and Medicaid Fraud

Key Fraud and Abuse Laws

Key Fraud and Abuse Laws:

- Physician Self-Referral Law (Stark)
- Anti-Kickback Statute
- False Claims Acts

Why Government Focuses on Fraud and Abuse-

- Increases healthcare expenses
- Skews patient care decisions
- Quality of care

Key Fraud and Abuse Laws, Cont.

- Physician Self-Referral Law (Stark)
  - 42 USC 1395(n)(n)
  - Prohibits physicians from referring patients to receive 'designated health services' payable by Medicare or Medicaid from entities where the physician (or family) has a financial relationship
  - Many exceptions apply
  - "Designated Health Services" include clinical laboratory, radiology, home health services, and inpatient/outpatient hospital services.
  - Strict liability: No intent is required.

Key Fraud and Abuse Laws, Cont.

- Anti-Kickback Statute
  - 42 USC 1320a-7b(b)
  - Prohibits the knowing and willful payment of 'remuneration' to induce or reward patient referrals or other business payable by the Federal health care programs.
  - Applies to both sides of the transaction, givers and receivers
  - Safe harbors protect certain types of arrangements
  - Intent matters
  - Criminal penalties and administrative sanctions may apply, up to $50,000 per kickback, plus 3x the amount of remuneration

Key Fraud and Abuse Laws, Cont.

- False Claims Act
  - 31 USC 3729-3733
  - Establishes illegality for submitting claims for payment to Medicare or Medicaid that are known, or should be known, to be false or fraudulent.
  - Fines up to 3x program loss plus $11,000 per claim filed
  - Stark and Anti-kickback violations can also result in False Claim Act liability.
  - Civil FCA-no intent required
  - Criminal FCA-can result in jail time
  - Whistleblower provisions
  - Deficit Reduction Act Requirements-must inform employees and business partners of federal and state False Claims Act provisions

Enforcement

Enforcement Sources -

- Medicare Recovery Audit Contractors (RACs)
- Medicaid RACs
- Medicaid Integrity Contractors (MICs)
- Zone Program Integrity Contractors (ZPICs)
- State Medicaid Fraud Control Units (MFCUs)
- Comprehensive Error Rate Testing (CERT)
- Payment Error Rate Measurement (PERM)
- OIG, Department of Justice, FBI, US Attorneys, State Attorney Generals…

Enforcement, Cont.

Possible Outcomes, if Problems are Identified:

- Provider Education and Outreach
- Ongoing/Continuous Audits
- Referrals to other Fraud Units/Organizations
- Repayments
- Suspension of Payments
- Revocation of Assignment (Medicare/Medicaid)
- Integrity Agreements
- Civil, Criminal, Administrative Penalties
- Jail Time

Cases and Trends

- Johnson & Johnson
  - $2.2 billion for off-label promotion and kickbacks
  - Ongoing huge settlements/cases with Pharma and Device companies and healthcare providers
  - Quality of care issues-anti-psychotic medication being marketed and prescribed for children and elderly with dementia

- Shands Healthcare in Florida
  - False Claims Act case, based on inpatient status vs. outpatient
  - $26 Million payment to Florida and the federal government
  - Whistleblower case

- Intermountain Healthcare, Utah
  - Physician service agreements and leases violated Stark, arrangements included bonuses based on referrals. "Technical" violations.
  - $25.5 million settlement
  - Self-disclosure

Cases and Trends, Cont.

- Halifax Health, Florida
  - Stark Violations, $85 million settlement
  - Claimed that arrangements with physicians were approved by attorneys
  - Whistleblower case-internal reports were ignored

- Dr. Steven Wasserman, Florida
  - $26.1 settlement
  - Dermatologist, kickback arrangement with pathology lab
  - Medically unnecessary services
  - Whistleblower case

- Tuomey Healthcare System
  - $237 million
  - Part time physicians reimbursed based on volume of referrals, not fair market value

Cases and Trends, Cont.

- **Trends to Watch**
  - Inpatient/Outpatient/Medical Necessity. Admission criteria and enforcement continues to evolve. Specific conditions/procedures heavily reviewed, such as stents and kyphoplasty for medical necessity. Short stays as False Claims?
  - Payments to Physicians-physician arrangements (Stark) including Medicaid. Physician Payment Sunshine Act going 'live' this year, hospitals should monitor published pharmaceutical and device company payments to their physicians, review Conflicts of Interest disclosures.

Cases and Trends, Cont.

•Trends to Watch

- Meaningful Use Payment Fraud. A Texas CFO indicted for making false statements and to get Meaningful Use funds. Also indicted for one count of identify theft. Up to 7 years in prison and fines up to $500,000. Expect government to continue reviewing the accuracy of these attestations.
- Healthcare Exchanges-marketing, identity theft. Online marketplaces create fraud and identity theft opportunities, potential security issues. Fake exchange sites set up. Also, patients can sign up and get health care before paying premiums, leaving hospitals at risk.
- Clinical Laboratories. The OIG has issued another Fraud Alert, as well as a report on excessive payments to laboratories. Enforcement of the Anti-Kickback Statute will continue, including fines and jail time.

Cases and Trends, Cont.

- **Trends to Watch**
  - Pharmaceutical and Device Company Kickbacks to Health Care Providers. The PPSA or "Sunshine Act" mandates that any manufacturer of medical supplies, medical equipment or pharmaceuticals will disclose to the Department of Health and Human Services (DHHS) any payments, gifts, or "transfers of value" over $10. The resulting disclosures will be publicly available in a database of transactions so that there will be "sunshine" on any financial relationships, direct or indirect, between providers and manufacturers. Data released to public Sept. 30, 2014.

  - Electronic Medical Records-copy/pasting, over-documentation. EMRs identified as making false records easier, increases risk of fraud as well in impacting quality of care with false records. Some EMRs 'auto-populate' data fields, creating false data in the medical record.

Areas of Focus for 2014

- **OIG Work Plan Audit Topics (Hospitals)**
  - New Inpatient Admission Criteria (Two Midnight Rule). OIG will assess impact and payments based on new criteria.
  - Outpatient Evaluation and Management Services Billed by Hospitals as New Patients. OIG will evaluate appropriateness of billed rate and service.
  - Cardiac Catheterization and Heart Biopsies. OIG will review billing compliance.
  - Oversight of Hospital Privileging. OIG assessment of how hospitals evaluate and credential medical staff
  - Inpatient and Outpatient Billing Requirements. OIG will continue various billing reviews.

Areas of Focus, Cont.

- **OIG Work Plan Audit Topics (Physicians)**
  - Chiropractic Services. Questionable billing and maintenance therapy
  - Diagnostic Radiology. OIG reviews medical necessity of costly tests
  - Evaluation and Management (E & M) services. Review appropriateness of payments and adequacy of records

Areas of Focus, Cont.

- **OIG Work Plan Audit Topics (Nursing Homes)**
  - Medicare Part A billing. OIG will review billing accuracy.
  - Medicare Part B billing. OIG will review billing patterns for Part B providers.
  - Hospitalizations. OIG will review preventable or unnecessary hospitalizations of nursing home patients.

Areas of Focus, Cont.

- **OIG Work Plan Audit Topics (Other New, Key Topics)**
  - ACA Eligibility and Security. OIG will review accuracy of controls in the marketplace, as well as security controls for CMS web infrastructure.
  - Security under Meaningful Use. OIG will review various entities to validate PHI is adequately protected.
  - Medicaid Eligibility. OIG will review accuracy of eligibility assessments.

Identifying Risk Areas

- **How Does the Government Do It?**

  - Data Analysis/Predictive modelling
  - New Legal/Regulatory Requirements
  - Recent Settlements
  - Audit Results
  - Tips and Whistleblowers

Identifying Risk Areas, Cont.

- **How Should Providers Identify Risk?**
  - Internal or External Review
    - Objective reviews, not department head evaluating self
    - Compliance, Internal Audit, consultants, attorneys
  - Risk Assessments-Multiple Processes
    - Interviews, surveys, department focused
  - Multiple Data Sources:
    - Not just OIG Work Plan.
    - Internal and external reviews
    - New laws and enforcement trends
    - hotline calls and compliance complaints

Identifying Risk Areas, Cont.

- **Identifying Risk-Data Analysis**

  - Claims and billing data identifies outliers. Identify potential upcoding or unusual patterns/high cost procedures being conducted
  - Payments to physicians link to contract. All payments should track to a contract. Payments should be consistent with contract terms.
  - Pepper Reports. Data used by regulators, helpful to review regularly to identify trends/outlier status as compared to other providers.

Strategies for Focusing Resources

- Contracts. Having solid processes in place, and monitoring compliance, can prevent Stark and Anti-Kickback issues, as well as potential inaccurate payments. (Especially physician contracts)
- Background Checks/Excluded Provider Checks. Hiring or contracting with excluded providers can result in fines or even exclusion from participation with Medicare/Medicaid.
- Medical Necessity/Inpatient Admissions. Guidance is continuing to evolve for inpatient admissions and observations. Medical necessity is a huge money-maker for government auditors.

Questions

Thank You!

Susan Walberg, JD MPA CHC
Vice President/National Director of Compliance
swalberg@kohlerhc.com
(301) 256-5010 – Cell

Kohler HealthCare Consulting, Inc.
www.kohlerhealthcareconsulting.com
(410) 461-5116 – Office

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