Medicare Fraud and Abuse and Your Practice

April 24, 2012
By Aubrey Westgate

The government is getting more aggressive—a lot more aggressive—in going after possible fraud. Here's how to keep your practice out of legal hot water.

When it comes to fraud and abuse, "most practices are making mistakes," says Andy Braver, a New York-based healthcare attorney, who spent five years running a medical diagnostic imaging center in Florida.

Such problems often occur, Braver says, when practices rely on billing software to type in codes. "All of a sudden you're billing for something that you were not doing just because you got a number wrong and you transposed something," he says.

While this may seem like a small mistake in the larger scheme of things, if it happens over and over again, it's less likely your offense will go unnoticed — especially today. And it's just one of the many mistakes you might be making that could get you into trouble for fraud and abuse.

"Practices could have been doing something for years that may not have drawn any red flags," Braver says. But now, as a result of new technology, the government is able to identify violations more quickly and easily than ever before. "Everything's changing," he says.

Time to pay attention

The Affordable Care Act (ACA) provides an additional $350 million to the Health Care Fraud and Abuse Control Program to ramp up antifraud efforts, which include increasing scrutiny of claims before payment, investing in sophisticated data analytics, and employing additional law enforcement agents.

Those efforts are already paying off. In fiscal 2011, the government recovered $4.1 billion in fraudulent healthcare payments, the largest amount ever collected in a single year, according to HHS.

That's a good thing for the economy, but for physicians, stepped-up enforcement also means more eyes are watching your every move. "Physicians really can't fly under the radar like they thought they used to be able to now," says Todd Rodriguez, a healthcare attorney with Fox Rothschild LLP in Exton, Pa.

New rules written into the healthcare reform law also tighten Medicare and Medicaid screening and enrollment processes, impose stricter federal sentencing for fraud offenses, inflict stronger civil and monetary penalties for violations, set forth a new requirement for providers to return overpayments to CMS within 60 days, and require that providers establish a fraud and abuse compliance program.

The healthcare reform law also makes it easier for the government to meet the requirements of charges under the Anti-Kickback Statute and the Healthcare Fraud Statute, notes healthcare attorney Amy Nordeng, counsel for the Medical Group Management Association Government Affairs Office in Washington, D.C. "The ACA is loaded with tools to help the government [fight fraud and abuse]," she says.

What to know

To ensure your practice is complying, have a firm understanding of the federal statutes related to fraud and abuse. Three of the most noteworthy are the Civil False Claims Act, the Federal Anti-Kickback Statute, and the Physician Self-Referral Act (also known as the Stark Law).

Physician Self-Referral: This prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies, according to the Office of the Inspector General (OIG). In other words, "a physician may not refer patients to a provider of designated health services where that physician or an immediate family member of the physician has a financial relationship, which means either a compensation relationship or an ownership relationship in that entity," says Rodriguez.

Stark is "particularly dangerous" for physicians, he says, because you do not have to have intent to violate it. Violations can result in monetary fines and possible exclusion from federal healthcare programs.
Anti-Kickback: This law prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs, according to the OIG. In other words, it prohibits anyone from offering, giving, requesting, or receiving remuneration in exchange for referrals of patients or services or goods covered by a federal payer program, says Rodriguez.

There is a lot of "gray area" under compliance with the Anti-Kickback Statute, says Robert Slavkin, a healthcare attorney with Akerman Senterfitt in Orlando, Fla. That said, the penalties for violating it are "much more dire." They include monetary penalties, imprisonment, and exclusion from the Medicare program. Intent is a factor.

Civil False Claims: This prohibits providers from submitting false claims for payment of government funds. It does not require that the submitter have actual knowledge that the claim was false. For instance, someone who acts in reckless disregard can be found liable, according to CMS. Penalties include monetary fines.

*For more on each of these laws, the exceptions, and the missteps you could be making in relation to them, visit [http://bit.ly/fraud-and-abuse](http://bit.ly/fraud-and-abuse) for a Q&A podcast with Rodriguez.*

How to deal
As mentioned earlier, the healthcare reform law requires that providers establish fraud and abuse compliance programs. Though final rules for such programs have not yet been released, it's smart to begin forming a program now — not only because it's required in the law, but because it's a great way to protect your practice.

"If [a violation] was a mistake, and it can be documented it's a mistake, the government is going to be much more cooperative in resolving the matter," says Slavkin. "The way a doctor puts himself in a defensible position is to have a compliance program."

In 2000, the OIG issued seven recommendations for compliance programs at individual and small-group practices. "That's what I recommend doctors start with," says Rodriguez.

Audit and monitor
The first OIG recommendation is to continually evaluate your practice's compliance level and identify your risk areas for noncompliance. Your highest risk area is likely in billing for the services you perform most frequently, says Rodriguez. As Braver points out, these mistakes will be the most obvious to enforcement officers. In addition, says Rodriguez, if you repeatedly bill for a service incorrectly, that can result in significant overpayments over time. If you need to return that money to the government, it can take quite a toll on your finances, especially if it's due to a mistake you've made repeatedly for months or years.

To avoid such issues, Rodriguez recommends conducting audits on a sampling of charts at least annually to monitor compliance. Focus especially on those high-risk areas, he says. In addition, consider involving an attorney in this process so that if you do find problems, they may be protected from compelled disclosure.

Establish standards and procedures
The OIG's second recommendation is to develop a method for dealing with risk areas. One way to do this is by including compliance procedures in your practice's policies and procedures manual, something Braver recommends.

In addition to a policy regarding frequent billing and coding audits, consider including:

- **Documenting standards.** Proper documentation of services is essential, says Braver. "You can't prove something happened without having the written record for it." And, if you need to explain why you chose to make a particular referral or why you wrote a prescription for a particular drug, documentation helps. "If a patient uses a specific treatment or drug or whatever that might be, write it down in the patient's file," he says.

- **Contract checkups.** Routinely ensure all contracts remain in compliance and they have not expired, says Rodriguez. Also check with an attorney before signing contracts. "Just because you have a signed contract in place doesn't make it OK. It needs to also comply with the other elements of the statutes or the exceptions," he says.

Designate a compliance officer
The third OIG recommendation is to identify a member of your practice to oversee your compliance program. This is also a recommendation of Slavkin's. Have one staff member oversee regular auditing, keep track of billing practices, ensure employees have the proper training and education, and so on, he says.

Train and educate
The OIG also recommends compliance training and education for staff members. Nordeng agrees it's important for practices to ensure employees are as educated as possible. Two useful resources are a
series of compliance training videos available on the OIG website and a quarterly compliance newsletter released by CMS that highlights the top issues auditors identify, she says.

**Respond to offenses; develop corrective action**

The fifth OIG recommendation is to determine what will happen if you identify a compliance issue. Though every situation is different, Nordeng suggests isolating the problem, assessing its scope, and of course, preventing it from happening again. Also, consider seeking counsel "with an educated attorney who knows the healthcare law," she says.

**Communicate and implement disciplinary standards**

OIG's sixth and seventh recommendations are to foster an "open door" policy with staff members when compliance issues arise and to outline consequences for employees who violate the statutes or fail to respect your policies.

Of course, it's best to prevent such issues from happening in the first place. A searchable database of individuals excluded from federal payer programs is available on the OIG website. When hiring, ensure candidates are not on any exclusion lists, says Nordeng. "You can avoid a lot of [compliance] problems by making sure at the beginning that you've properly screened."

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This article originally appeared in the May 2012 issue of Physicians Practice.

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