FRAUD AND ABUSE IN INTERVENTIONAL PAIN MANAGEMENT

Erin Brisbay McMahon
Wyatt, Tarrant & Combs, LLP
Lexington, Kentucky
emcmahon@wyattfirm.com

LEARNING OBJECTIVES:

• Why should you care about violations of the fraud and abuse laws in your practice?
• What federal statutes focus on healthcare fraud and abuse?
• What is the main difference between the criminal and civil False Claims Acts?
• What are the “safe harbors” that do not violate anti-kickback laws?
LEARNING OBJECTIVES:

- What are the Designated Health Services covered by Stark Law?
- What arrangements trigger Stark Law scrutiny?
- Why is there an increased focus on prescription pain relief?
- When are Civil Money Penalties imposed?
- Distinguish between mandatory and permissive exclusions from federal government health programs

Section 1

WHY YOUR PRACTICE NEEDS TO THINK ABOUT FRAUD AND ABUSE ISSUES
Why Should I Care?

• The US Government makes money – lots of it – from suits and investigations of fraud against the United States.
• In FY 2003, the federal government recovered $1.7 billion in health care fraud suits and investigations.

Why Should I Care?

• Your patients and your employees have incentive to look for health care fraud because of the False Claims Act
• Even if a False Claims case never goes to trial, whistleblowers can receive millions of dollars as part of a settlement
Why Should I Care?

• Criminal penalties
• Corporate Integrity Agreements
• Exclusion from Medicare, Medicaid, and other government funded health programs

Health Care Fraud and Abuse Control Program

• HIPAA established a national Health Care Fraud and Abuse Control Program to be implemented by:
  – the United States Attorney General
  – the Department of Health and Human Services (HHS)
  – the Office of Inspector General (OIG)
Purpose of HIPAA’S Health Care Fraud and Abuse Control Program

• to combat health care fraud and abuse

HIPAA Program Results

• False payments in excess of $5.69 billion have been recovered since 1997.
• During 2003, HHS excluded 3,275 individuals from Medicare and Medicaid programs due to convictions related to Medicare and Medicaid, patient abuse or neglect and licensure revocations.
Collaboration creates problems – 
Cecil Knox case

-Office of Inspector General, Department of Health and Human Services
-Defense Criminal Investigative Service, Department of Defense
-Dublin, Virginia, Police Department
-Drug Enforcement Administration
-Federal Bureau of Investigation
-United States Marshal’s Service
-Office of the Inspector General
-Medicaid Fraud Control Unit, Office of the Attorney General, Commonwealth of Virginia
-Montgomery County Sheriff’s Department
-Office of the Medical Examiner, Western Region, Commonwealth of Virginia

Collaboration creates problems – 
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-Pulaski County Commonwealth’s Attorney’s Office
-Radford Police Department
-Roanoke, Virginia, Police Department
-Roanoke County, Virginia, Police Department
-Salem, Virginia, Police Department
-Office of the Inspector General, Social Security Administration
-Bureau of Alcohol, Tobacco, Firearms, and Explosives
-Criminal Investigation Division, Department of Veterans Affairs
-Health Care Fraud Unit, United States Attorney’s Office
-Bureau of Criminal Investigation, Virginia State Police
-The Trigon Blue Cross Blue Shield Financial Investigation Unit
In Health Care, FRAUD and ABUSE issues surround:

• Billing & Coding
• Reimbursement
• Compliance with Federal Anti-Kickback Statutes
• Compliance with Self-Referral Statutes
• Compliance with Controlled Substance Statutes

Section 2

STATUTES THAT FOCUS ON HEALTHCARE FRAUD AND ABUSE
1. Criminal and Civil False Claims Acts
2. Federal Anti-Kickback Statute
3. Federal Self-Referral Law (Stark Law)
4. Controlled Substances Act
6. Mandatory & Permissive Exclusion Authorities

1.(a) The Criminal False Claims Act:

- makes it a felony to make or cause to be made any “false statement or representation of material fact in any application for any benefit or payment under a Federal health care program”
- includes requests for reimbursement
Penalties for violating the Criminal False Claims Act include:

• term of imprisonment of not more than five years
• Fines up to $25,000
• Exclusion from federally funded health care programs

1.(b)The Civil False Claims Act

• imposes liability if one “knowingly” submits or causes to be submitted a false or fraudulent claim for payment to the federal government
• specific intent to defraud is not required
• Can be held liable for acting with reckless disregard of the truth of the information being submitted as a claim for payment
To avoid a claim of reckless disregard…

• It is critical to regularly check the codes supplied in Medicare reimbursement requests against the patient records

Civil False Claims Act

• also prohibits:
  - knowingly using a false record to get a false claim paid;
  - conspiring to get a false claim paid; and
  - knowingly making or using a false record to avoid an existing obligation to pay the federal government
Statute of Limitations

• Claims can be brought up to ten years after a violation was committed, depending on the circumstances of how the violation was discovered

Penalties – Civil False Claims Act

• treble damages
• fines of $5,500 - $11,000 per claim
• possible exclusion from Medicare and Medicaid
2. The Federal Anti-Kickback Law

- A criminal statute that prohibits the offer or receipt of anything of value which is intended to induce the referral of a patient for an item or service that is reimbursed under a federal health care program, including Medicare and Medicaid

Penalties for violating the Federal Anti-Kickback Law include:

- term of imprisonment not to exceed five years
- treble damages
- damages and penalties up to $50,000 for each violation
- Exclusion from federally-funded health care programs
Why does the law prohibit referrals for remuneration?

- It can distort medical decision-making
- Cause overutilization of services or supplies
- Increase costs to Federal health care programs
- Result in unfair competition by shutting out competitors who are unwilling to pay for referrals

Safe Harbors

- There are certain exceptions that do not violate Anti-Kickback laws for legitimate business relationships
- known as “safe harbors”
Safe Harbors Include:

- protections for payments resulting from certain investments
- payments for rentals of space and equipment
- payments to bona fide employees
- payments under contracts for services
- payments relating to physician referral services
- payment relating to the purchase and sale of physician practices

- remuneration paid pursuant to warranties and in the form of discounts
- remuneration to group purchasing organizations
- certain arrangements with preferred providers and in Medicare/Medicaid managed care arrangements
Many common business arrangements have the potential to violate state or federal Anti-Kickback laws.

Unless w/in a Safe Harbor, physician practices should NOT have arrangements with:

- hospitals
- ambulatory surgery centers
- durable medical equipment suppliers
- diagnostic imaging centers
- clinical laboratories
- billing companies
- or others that provide payment or remuneration for referrals of patients
3. Federal Self-Referral Law (Stark Law)

- It prohibits physicians from making referrals for certain designated health services (DHS) to entities where (a) the physician (or a member of the physician’s immediate family) has a direct or indirect financial relationship and (b) the service is billed to Medicare or Medicaid.

Penalties for violating Stark Law include:

- civil money penalties of up to $15,000 per claim and $100,000 per scheme
- exclusion from federally-funded health care programs
The DHS covered by Stark Law include:

1) clinical laboratory services  
2) physical therapy services  
3) occupational therapy and speech language pathology services  
4) radiology services (MRI, CAT scans, Ultrasounds)  
5) radiation therapy services and supplies  
6) durable medical equipment and supplies  
7) parenteral and enteral nutrients, equipment and supplies  
8) prosthetics, orthotics, and prosthetic devices  
9) home health services  
10) outpatient prescription drugs  
11) inpatient and outpatient hospital services
Be aware that many common financial arrangements trigger scrutiny under Stark laws.

Including:

- Referrals within a group practice;
- Medical director agreements;
- Investment interests in a hospital or ASC;
- Arrangements between physicians and other DHS providers;
- Physician part-time employment or independent contractor agreements;
- Lease agreements for space or equipment;
• Hospital-physician recruitment agreements;
• Marketing agreement with entities owned by physician or hospital investors that do not reflect fair market value payments for necessary services;
• Practice compensation programs that reward shareholders or employee physicians based on orders of designated health services.

Stark Law Exceptions

• There are exceptions to Stark Law
• Arrangements that trigger Stark must meet an applicable exception
• The requirements for meeting the exceptions are stringent and sometimes complex
4. Controlled Substances Act

- The DEA monitors prescriptions of controlled substances pursuant to the Controlled Substances Act
- The DEA and OIG are paying special attention to prescriptions for pain relief

Why the increased focus on prescription pain relief?

- increases in types of pain prescriptions available
- increases in the number of prescriptions given for these medications
- evidence of doctor shopping to obtain these pain prescriptions
5. Civil Monetary Penalties

- OIG has authority to impose CMPs on anyone who knowingly presents or causes to be presented certain false or improper claims to a state or federal employee or agent
  - $10,000/item or service
  - $50,000/act
  - treble damages

CMPs are imposed when practices knowingly file claims for:

- services not provided as claimed (e.g., upcoding);
- medical or other items or services that are fraudulent;
- services of a physician or services provided “incident to” a physician’s service if the physician:
  - was not licensed as a physician;
  - obtained his/her license through misrepresentation;
  - falsely represented to patient that s/he was certified by a medical specialty board;
CMPs are imposed when practices knowingly file claims for:

- medical or other items or services furnished during a time in which the person was excluded from participation in the program under which the claim was made; or
- a pattern of medical or other items or services that a person knows or should know are not medically necessary

Beneficiary Inducement CMPs

- transfer of items or services for free or other than fair market value
- waiver of copays, coinsurance, or deductibles except when:
  - not offered as part of ad or solicitation;
  - practice does not routinely waive coinsurance and deductibles; and
  - practice (1) waives coinsurance and deductible after good faith determination of financial need, or (2) fails to collect coinsurance and deductible after reasonable collection efforts
6.(a) Mandatory Exclusion

- Conviction of a criminal offense related to the delivery of an item or service under Medicare or Medicaid;
- Conviction of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of a health care item or service;

6.(a) Mandatory Exclusion

- Conviction of any felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct under federal or state law relating to health care fraud; or
- Any felony conviction under federal or state law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance
6.(a) Mandatory Exclusion

- Conviction –
  - judgments entered by a court
  - findings of guilt by a court
  - pleas of guilty or nolo contendre accepted by a court
  - individual is participating in first offender or similar program where judgment has been withheld

Mandatory exclusion is for a minimum of 5 years (increases to 10 for repeat convictions); exclusion can be permanent for multiple convictions.
6.(b) Permissive Exclusion

- OIG has discretion to exclude individuals and entities for the following:
  - convictions for offenses under federal or state law for:
    - criminal misdemeanors related to health care program fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct
6.(b) Permissive Exclusion

- OIG has discretion to exclude individuals and entities for the following:
  - convictions for offenses under federal or state law for:
    - obstruction of justice in healthcare investigations;
    - misdemeanors related to unlawful manufacture, distribution, prescription, or dispensing of controlled substances

- revocation/suspension of individual/entity’s license to provide health care, incl. surrender of license pending disciplinary hearing for reasons relating to competence or financial integrity
- suspension or exclusion from federal or state health care programs for reasons relating to competence or financial integrity
6.(b) Permissive Exclusion

• OIG has discretion to exclude individuals and entities for the following:
  - submitting claims substantially in excess of usual charges;
  - providing unnecessary or substandard services;
  - activities involving fraud or kickbacks;
  - entities controlled by persons convicted of program-related abuses, or excluded from Medicare/Medicaid, or had a CMP imposed;
  - individuals controlling a sanctioned entity in which the person knew/should have known of the action constituting the basis for the conviction/exclusion, or being an officer or managing employee of such entity;
  - entity’s failure to disclose required information;
  - failure to grant immediate access to a facility, records, or documents on reasonable request of HHS, OIG, MFCU, or other state agency;
6.(b) Permissive Exclusion

- OIG has discretion to exclude individuals and entities for the following:
  - defaulting on education loans/scholarship obligations in connection with health professional education made or secured, in whole or in part, by HHS

Sources for Slides

- Stark Law – 42 U.S.C. § 1395nn
- Controlled Substances Act – 21 U.S.C. § 801
- CMPs - 42 U.S.C. § 1320a-7a
- Exclusion - 42 U.S.C. § 1320a-7(a)-(c)
Sources for Slides, cont’d


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- The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2003 (Dec. 2004).
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  (http://www.nebraskamedicare.com/policy/fraud.htm)
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  (http://www.usdoj.gov/dea/pubs/pressrel/pr102301.html)
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Sources for Slides, cont’d

- HHS-OIG-Fraud Prevention and Detection
  (http://www.oig.hhs.gov/fraud.html).
- Physician Information Resource
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• Health Care Fraud and Abuse: Practical Perspectives, Linda A. Baumann ed. (ABA Health Law Section 2002).