

Fraud and Abuse in NC

By

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The federal government estimates that it lost 12.5 billion dollars in improper Medicare payments in the year 2000.ⁱ This accounts for approximately 10% of total Medicare costs.ⁱⁱ The HHS Office of Inspector General states in its listserv footer (a regular e-mail sent to those who sign up), “The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) protects the integrity of HHS programs from fraud, waste and abuse through its nationwide network of auditors, investigators and analysts. In FY 2002, OIG saved taxpayers a record \$21 billion, excluded 3,448 people and companies from Medicare/Medicaid reimbursement, secured 517 criminal convictions and 236 civil actions.” These numbers are staggeringly high, so it makes sense that fraud and abuse is a top priority for federal and state government. The government has been pursuing wrongdoers in the health care sector for years, and its vigilance only continues to increase. Its efforts are paying off. In fact, one estimate states that the government gets back fourteen dollars for every dollar it spends in fighting fraud and abuse.ⁱⁱⁱ That is a great return on investment.

Fraud and abuse is both a national issue and a local one. Healthcare organizations should be sure that they are in compliance with federal and state regulations, particularly

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in light of the increased scrutiny by the HHS Office of Inspector General (OIG), the NC Department of Health and Human Services (NCDHHS), and Cigna Medicare (Cigna).

We are all familiar with some of the federal government initiatives to combat fraud and abuse. There is the Medicare Integrity Program, Operation Restore Trust, the Correct Coding Initiative, the joint hearings between the Federal Trade Commission and the Department of Justice, among others. The government is also going to great expense to educate beneficiaries on how to spot problems and whom they should call.

NCDHHS is involved in detecting fraud and abuse as well. It has automated technology that electronically searches claims for patterns that may indicate illegal billing. Information from this system is then made available to the Attorney General's Investigation Unit that investigates and prosecutes fraudulent providers.

CIGNA is the Medicare carrier for North Carolina, and it too has anti-fraud measures in place. CIGNA clearly states on its website,

“CIGNA Medicare maintains a committed Anti-Fraud Unit. Our Unit works closely with the Health Care Financing Administration (HCFA), fellow Medicare contractors, the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), the United States Attorney's Offices, and other partners to identify fraud and abuse. We develop cases for referral to federal law enforcement authorities, support civil and/or criminal prosecutions, recover lost money, and pursue the exclusion of bad providers from the Medicare system.”^{iv}

It is not the time for providers to become complacent about compliance with healthcare regulations. With the current emphasis on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it will be tempting to focus purely on privacy. However, the state and federal governments will continue to enforce *all* regulations, particularly those that pertain to fraud and abuse. This article will define what fraud and abuse is, the penalties associated with it, and ways to prevent it from occurring.

What is Fraud and Abuse?

Fraud, as defined by the Centers for Medicare and Medicaid Services (CMS), is an intentional deception or misrepresentation that could result in the payment of unauthorized benefits. It may be a scheme or the use of false pretenses, but the actions taken are knowing and willful. Some examples of fraud include billing for services not rendered, receiving kickbacks, using an inappropriate provider number to get paid, offering incentives to Medicare patients such as waiving co-pays, falsifying information on applications or forms files with the government, and misrepresenting non-covered services as medically necessary.

Abuse also involves payment for items or services when there is no legal entitlement, however, generally there is no knowledge of illegality or intentional misrepresentation. These are actions that are inconsistent with sound medical, business, or fiscal practices, and they directly or indirectly result in higher costs to the Medicare program through improper payments. Some examples of abuse include using procedure codes that describe more extensive services than those actually preformed, collecting more than the appropriate coinsurance, or mistakenly submitting duplicate claims.

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Physicians should take some comfort in the fact that the OIG believes “the great majority of physicians are working ethically to render high quality medical care and to submit proper claims.”^v The OIG also attempts to dispel the notion that innocent billing errors will subject physicians to penalties and jail. However, physicians and other providers do have a duty to “reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate.”^{vi}

Besides basic billing errors or billing schemes, there are some other aspects to a physician practice that the government watches carefully. The following are high-risk areas:

- Referrals. Referrals have significant potential for abuse, and therefore certain procedures should be followed. When a physician makes a referral, there should be a system in place to ensure that only the services or tests ordered were rendered. Wherever possible include the reason for the services being ordered. Do not leave it up a lab to determine why the tests were needed. Do not sign blank certification forms for durable medical equipment (DME), and certainly do not certify the need for supplies for patients that haven't been examined.
- Services by non-physician practitioners. Coverage for services by certain non-physician practitioners (such as nurse practitioners and physician assistants) is permitted under certain circumstances without the direct supervision of a physician. Pay close attention to any restrictions by Medicare or the scope of licensure to avoid violations.

- Billing “Incident to”. This causes much confusion for many physicians. In a nutshell, non-physician providers such as nurse practitioners and physician assistants may bill “incident to” the physician at his rate of reimbursement if the physician provides direct supervision. There are several components to the definition of “direct supervision,” but usually it requires the physician’s presence in the building and a certain amount of oversight. If there is no direct supervision, nurse practitioners or physician assistants must bill under their own provider number at a reduced rate. This is an oversimplification of the rule; so before implementing your own policy, review the requirements in great detail.
- Anti-kickbacks. It is illegal to receive money or other compensation for referrals. Gifts that are more than nominal in value are considered suspect by the government. It is a good idea to prohibit gift giving by drug companies, other physicians, and medical entities.
- Self-referrals. There are state and federal prohibitions against a provider making a referral of a patient to any entity with which the provider or the practice has a financial relationship. This law is fairly complex, and there are many exceptions. A good rule of thumb is to consult an attorney any time such an arrangement is contemplated.
- Other coding issues. Other common examples of fraud and abuse related to coding include upcoding, unbundling, duplicate billing, overcharging. These are all illegal methods of increasing reimbursement.

- Non-covered Services. There is no Medicare payment associated with certain procedures (e.g. routine physicals, personal convenience items, and cosmetic surgery). Therefore, it is permissible to charge the patient what is appropriate, but it is important to let the patient know in advance that he or she is personally responsible for payment (Also known as an Advance Beneficiary Notice). Be sure ABNs are used appropriately, and employ the new form required as of January 2003.
- Billing Services. Using a billing service does not relieve any responsibility for accurate claims. The practice is ultimately accountable for everything submitted on its behalf. That is why it is so crucial to select a reputable and reliable billing service. In order to avoid the appearance or temptation of impropriety, payment for the billing service should be at a single rate rather than based on the number of claims filed. In addition, any correspondence with Medicare should be directed to the practice rather than the billing service. That way the practice is aware of any issues. Periodic audits should be conducted and documented as proof of due diligence.
- Credit Balances. If there are multiple payors for the same service, the secondary payor should be reimbursed as appropriate. (Often the secondary payor is Medicare.)

Penalties for Fraud and Abuse

When Medicare determines that a provider may be committing fraud, the case is usually referred to the OIG or the FBI for further investigation. The federal government

may also work with state government on the case. A violator may be subject to civil prosecution, criminal prosecution, or both depending on the statute or statutes violated.

There are many statutes that affect health care. Some federal statutes are listed below:

- 18 U.S.C. Section 1347: Health care fraud
- 18 U.S.C. Section 669: Theft or embezzlement in connection with health care
- 18 U.S.C. Section 1035: False statements in connection with health care
- 18 U.S.C. Section 1518: Obstruction of a Federal health care fraud investigation
- 18 U.S.C. Section 371: Conspiracy to commit fraud
- 18 U.S.C. Section 287: False Claims
- 18 U.S.C. Section 1001: False statements
- 18 U.S.C. Section 201: Bribery
- 18 U.S.C. Section 1320: Kickbacks
- 18 U.S.C. Section 1956-57: Money laundering
- 18 U.S.C. Section 1962: RICO Act
- 18 U.S.C. Section 1343: Wire fraud
- 18 U.S.C. Section 1341: Mail Fraud

Punishments can include significant monetary fines, prison, exclusion from federal healthcare programs, and license revocation by the state. There are many examples on government websites of providers who have been sanctioned, lost their practices, or gone to jail.

Some specific penalties listed by statute are as follows:

- The False Claims Act provides fines of up to \$10,000, damages up to three times the amount of the fraudulent submission, and up to five years in prison.
- The Anti-Kickback Provisions of the Social Security Act provide for fines of up to \$25,000 and up to five years in prison.
- Civil Monetary Penalties (CMP) provide for fines of up to \$50,000 and damages up to three times the amount of the fraudulent submission.
- The Racketeer Influenced and Corrupt Organizations (RICO) Act has been used in Medicare fraud cases. Those convicted criminally can be sentenced to up to 20 years in prison. Civil conviction under RICO provides for asset forfeiture.
- The Health Insurance Portability and Accountability Act created a new crime called Health Care Fraud. This crime allows for up to ten years in prison, up to 20 years if serious bodily injury results, or up to life in prison if death occurs.

Fraud and Abuse Prevention

Obviously there are some tremendous deterrents with respect to fraud and abuse for providers. Fortunately, there are ways to prevent fraud and abuse from occurring. The OIG has recommended that every organization implement a compliance program designed to detect potential violations and correct them. In the year 2000, the OIG published the “Compliance Program Guidance for Individual and Small Group Physician Practices”.^{vii} In that document, the OIG lists and describes what it views as the fundamental components of an effective compliance program. The OIG makes it clear that a compliance plan is not mandatory (except in the case of Corporate Integrity Programs), however, it suggests that practices of every size devote some resources to the

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effort. In April 2003, the OIG published “Corporate Responsibility and Corporate Compliance: A Resource for Health Care Board of Directors”^{viii} which was designed to help educate board members on how the organization handles compliance issues and whether it is complying with applicable laws.

A well-designed compliance program has far-reaching benefits. It should reduce the chances that an audit will be conducted by the state or federal government by helping to minimize billing mistakes. A compliance program should speed and optimize the proper payment of claims, and it will alert the practice to any improper coding patterns. Another noteworthy advantage is the reduction of fines if a practice is sanctioned. The False Claims Act has a formula it applies to lessen the penalty if a practice has what is considered an “effective compliance program.”

The OIG has identified seven key elements for an effective compliance program:

- Implementing written policies, procedures, and standards of conduct;
- Designating a compliance officer and compliance committee;
- Conducting effective training and education;
- Developing effective lines of communication;
- Enforcing standards through well-publicized disciplinary guidelines;
- Conducting internal monitoring and auditing; and
- Responding promptly to detected offenses and developing corrective action.

The OIG has provided details and suggestions for implementing the above elements. The process will involve considerable analysis and reflection on current habits and procedures and how to improve them. Billing and coding audits are important tools in discovering weaknesses. Note that the OIG is very specific that if a billing error is discovered, it is the provider's duty to correct the mistake and return any overpaid money. It is considered fraud if repayments are not made.

If your practice does not yet have a compliance program, there are some steps you can take right away.

- Assign someone to read CIGNA's Medicare Bulletin word for word and be in charge of implementing changes as necessary. Sometimes these Bulletins contain the only notification a practice will receive regarding major policy changes.
- Check the exclusions database for all current employees and any potential hires.^{ix} Currently, there are 336 people in NC on the excluded list.^x
- Keep all provider numbers kept strictly confidential.
- Start a binder with any compliance related information. Document all efforts the practice makes in preventing fraud and abuse, whether it is staff education or implementing a new policy.
- Make plans to implement a compliance program!

It is difficult for providers to stay abreast of all the regulations that are applicable to the health care industry. It can seem overwhelming and frustrating at times. The key is to find a trusted advisor that can help implement the appropriate policies and perform

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regular audits. Break the process down into small tasks and it will seem much more manageable. The most important thing is to make a plan and take action.

ⁱ Improper payments reported by Federal Agencies, GAO, Report No. GAO-02-131R, November 2001.

ⁱⁱ Medicare Learning Network Computer-Based Training – Fraud and Abuse. Available at www.cms.hhs.gov/medlearn/medicare_fraud.pdf. Accessed August 1, 2002.

ⁱⁱⁱ Statement of Bruce Merlin Fried, Director, Center for Health Plans and Providers on “Combating Medicare Waste, Fraud, and Abuse Through Information Technologies” before the House Committee on Commerce Subcommittee on Oversight and Investigations, September 29, 1997. Available at <http://www.hhs.gov/asl/testify/t970929a.html>, Accessed August 1, 2002.

^{iv} www.cignamedicare.com

^v 65 FR 59434 (2000). Available at <http://www.oig.hhs.gov/fraud/complianceguidance.html>, Accessed August 1, 2002.

^{vi} *Id.*

^{vii} *Id.*

^{viii} Available at <http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRscGuide.pdf>, accessed April 23, 2003.

^{ix} Available at <http://exclusions.oig.hhs.gov/search.html>. Accessed April 23, 2003.

^x Available at <http://exclusions.oig.hhs.gov/bystate2.html>. Accessed April 23, 2003.