# Compliance & Revenue Cycle Are they mutually exclusive?

*Compliance, Billing Fraud & False Claims*

*Nashville MGMA*

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Kraft Healthcare Consulting LLC

# Speaker Introduction

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# Overview

## Compliance and Revenue Cycle Management (RCM)

Can revenue and compliance co-exist or are they mutually exclusive?

Compliance and RCM each have their own role in a practice. Practices can achieve the maximum benefit if the 2 are tied together. A culture of compliance should always be primary goal. Compliance shouldn't be viewed as an added cost of RCM.

# Compliance

- Healthcare compliance matters to all medical organizations – no matter the size of the practice or type of facility.
- Compliance encompasses everything from eliminating cloned EHR records and ensuring appropriate documentation to EMTALA, Stark, False Claims Act and Anti-Kickback Statute.
- Why is a compliance program important?
  - An effective compliance program can help you find, identify, and proactively correct potential areas of vulnerability.
  - A federal landmark case court ruled that failure to maintain an effective program was grounds to allege the company submitted false claims with "***reckless disregard***"
- Effective vs. Active Compliance Plans

# Core Elements of a Compliance Program

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- Written policies, procedures, and standards of conduct
- Designated compliance officer responsible for monitoring compliance efforts and enforcing practice standards
  - Clearly defined roles and responsibilities
  - Authority to report directly to the head of the organization
- Effective training and education for all levels of employees
- Effective lines of communication to encourage individuals to make complaints regarding compliance items without fear of retaliation
- Internal monitoring and auditing of systems to assess the effectiveness of the compliance program and identify issues
- Enforcement of standards through well-publicized disciplinary guidelines for employees who fail to comply with requirements
- Prompt response to detected problems through corrective actions

# Designate Compliance Officer/Team

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- Overview:
  - Develop a corrective action plan
  - Oversee the practice's adherence to that plan
- Compliance Contacts:
  - Split the workload
    - One contact may oversee Standards and Procedures
    - One may oversee audits
    - Another  oversee education
  - Outsource or Share
    - Ensure sufficient interaction with the practice

# Compliance Team Job Duties

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- Suggested Job Duties:
  - Oversee and monitor implementation of compliance
  - Establish methods such as periodic audits: to improve the practice's efficiency and quality of services, and to reduce the practice's vulnerability to fraud and abuse
  - Revise the compliance program periodically with changes in the needs of the practice, changes in the law, changes in Government and private payor health plans
  - Develop, coordinate and participate in training programs that focus on the components of the compliance plan, and seeks to ensure that training materials are appropriate

# Conduct Training and Education

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- Educational Goals:
  - Determine ***who needs training*** (both in coding and billing and in compliance)
  - Determine ***the type of training*** that best suits the practice's needs (*e.g.*, seminars, in-service training, self-study or other programs)
  - Determine ***when and how often*** education is needed and how much each person should receive
- Compliance Training Goals:
  - All employees will receive training on how to perform their jobs in compliance with the standards of the practice and any applicable regulations
  - Each employee will understand that compliance is a condition of continued employment

# Effective Lines of Communication

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- Open, meaningful communication:
  - Report conduct that a reasonable person would believe to be erroneous or fraudulent
  - Create user-friendly, anonymous drop box for reporting
  - Provisions that state failure to report violates compliance
  - Develop a simple and readily accessible procedure to process such reports
  - Provide a provision in the manual that there will be NO retribution for reporting in good faith

# Enforcing Disciplinary Standards

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- Ensure that All Standards and Guidelines are well publicized and accessible
- Consequences:
  - Consistent and appropriate actions
  - Up to and including termination
  - Failure to detect and/or report may be subject to discipline

# Compliance Tips

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- Implement a process to verify all clinical licenses online.
  - DO NOT accept paper copies.
- Implement a process to conduct OIG exclusion checks for **all employees**:
  - upon hire
  - frequency (the OIG standard is monthly) thereafter.
- If your practice becomes the target of an audit, seek expert guidance prior to responding to:
  - help you understand the potential issues that your practice may face
  - allow you to index all documents submitted
  - help you coordinate an appropriate response

# RCM and Compliance

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The following RCM operations are examples of items that should be reviewed to ensure compliance:

- Documentation Reviews
- Coding
- Billing (Patient and Insurance)

# Documentation Guidelines

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- The medical record must be complete and legible
- The encounter/visit note must include:
  - **Chief Complaint**: Why is this patient being seen?
  - **History**: Brief background on the patients past, family, medical and social history – relevant to the Chief Complaint
  - **Physical Exam:** Pertinent to why the patient is being seen and must be unique
  - **Prior Diagnostic Testing:** Labs, X-Rays, etc.
  - **Assessment & Clinical Impression:** This should include the physicians plan for treatment as well as any medications ordered, or further testing/procedures to be done. Also knows as the medical decision making

***IF it is not documented, it is not done. Nothing may be assumed!***

***Documentation has the potential to be reviewed by many agencies, and it must be able to be easily inferred.***

# Medical Record Documentation Tips

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- **Be** specific to the patient
- **Be** specific to the condition at the time of the encounter
- **Reflect** accurately the services performed
- **Support** the necessity for the services
- **Identify** clearly who performed the services and assessments received
- **Identify** clearly the author of each note or entry
- **Identify** clearly the date and time that each note or entry was made

# Coding Compliance Review

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- Coders are typically certified and knowledgeable on the coding and documentation guidelines, this ensures claims are being submitted correctly, keeping the providers compliant
- Rules and regulations are changing yearly, mandated by CMS, NCCI, and private payers
- If rules and regulations are not followed potential penalties can occur, ongoing audits must be a part of a compliance plan to avoid potential penalties and consequences.

***Proactive > Reactive***

# Office of the Inspector General

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- The OIG is the independent oversight agency for the United States Department of Health & Human Services.
- The OIG's mission is to protect the integrity of the Federal health care programs and to promote the health and welfare of program beneficiaries.
- The OIG produces three core publications:
  - **The OIG Work Plan**
  - **The Semiannual Report to Congress**, which summarizes the OIG's most significant findings, recommendations, investigation outcomes, and outreach activities in six-month increments
  - **The Compendium of Unimplemented Recommendations**, which contains open recommendations from prior periods that, if implemented, will save tax dollars and improve programs.

# OIG Work Plan

- The OIG publishes its Work Plan annually.
- The Work Plan lists all of the various projects that will be addressed during the fiscal year by:
  - Office of Audit Services
  - Office of Evaluation and Inspections
  - Office of Investigations
  - Office of Counsel to the Inspector General
- The Work Plan provides a summary of all new and ongoing reviews and activities that the OIG plans to pursue during the next fiscal year and beyond.

# False Claims Act (FCA)

# False Claims Act (FCA)

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- The FCA (31 U.S.C. § 3729) makes it unlawful to, among other things:
  - knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval
  - knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim
  - knowingly make, use, cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government
  - knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government

# False Claims Act (FCA)

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## Intent

- "Knowing" and "knowingly" mean:
  - actual knowledge of the information
  - deliberate ignorance of the truth or falsity of the information
  - reckless disregard of the truth or falsity of the information
- Federal FCA is not intended to reach mere negligence.
- No proof of specific intent to defraud is required.

## Penalties

- Violations of the FCA are punishable by:
  - Three times the amount of damages which the government sustains as a result of the false claim
  - Penalties of $21,916 (in 2017) per false claim
  - Trebling of damages and penalties are mandatory if defendant goes to trial and loses
  - Discretionary exclusion from participation in the Medicare and Medicaid programs

# False Claims Act Violations

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- Submitting a false claim to the government to obtain payment.
- Submitting a claim for medically unnecessary services.
- Knowingly making false statements or providing false information.
- Falsifying records.
- Double-billing for items or services.
- Upcoding – Using a billing code, other than the intended code, to receive a greater payment.
- Submitting bills for items or services never provided.
- Filing a claim for payment in which the services were not rendered exactly as claimed.
- Filing a claim for a physician's service, when the service was actually provided by an unlicensed physician or misrepresented that the physician was certified in a particular medical specialty.

# FCA: A Math Lesson

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100 false claims for a miscoded procedure resulting in an overpayment of $1,000 for each claim. How much could it be?

Damages: 100 x $1,000 = $100,000

Penalties: 100 x $10,957 (minimum penalty) = $1,095,700
100 x $21,916 (maximum penalty) = $2,191,600

**TOTAL: Between $1,195,700 and $2,291,600**

# FCA: Qui Tam Provisions

- Or, what about that nurse practitioner?
- The "Qui Tam" provisions of the False Claims Act allow private citizens (called "relators") with knowledge of past or present fraud to file suits on behalf of the federal government
- If the "whistleblower suit" is successful, the relator may receive 15% to 30% of the government's recovery
- Defendant is also liable for relator's "reasonable" attorney's fees

# Civil Monetary Penalties Law

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- The Civil Monetary Penalties Law authorizes the imposition of CMPs for a variety of health care fraud violations. Different amounts of penalties and assessments may be authorized based on the type of violation. Penalties ranged from $21,563 to $73,568 per violation in 2016.
- CMPs also may include an assessment of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received.
- Violations that may justify CMPs include:
  - Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
  - Presenting a claim you know, or should know, is for an item or service for which Medicare will not pay
  - Violating the Anti-Kickback Statue

# Anti-Kickback Statute (AKS)

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- The AKS (42 U.S.C. § 1320a-7b(b)) prohibits knowingly and willfully offering, paying, soliciting, or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for:
  - referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal healthcare program; or
  - purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal healthcare program

# Physician Self-Referral Law (Stark Law)

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The Stark Law (42 U.S.C. §§1395nn et seq.) applies to situations where a physician (or an immediate family member) has a financial relationship with an entity:

- The physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made by the Medicare program; and
- The entity may not bill any individual, third-party payor, or other entity for designated health services furnished pursuant to a prohibited referral.

**Example:** A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

**Penalties:** Penalties for physicians who violate the Stark Law may include fines, CMPs up to $23,863 (in 2016) for each service, repayment of claims, and potential exclusion from all federal healthcare programs

# Anti-Kickback Statute (AKS)

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- Violations of the AKS can be either criminal and/or civil and are punishable by:
  - 5 years imprisonment
  - Fine of up to $25,000
  - Civil monetary penalty (CMP) up to $73,588
  - Exclusion from participation in the Medicare and Medicaid programs

# AKS vs. Stark Law

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| | THE ANTI-KICKBACK STATUTE | THE STARK LAW |
|---|---|---|
| **Prohibition** | Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business | • Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies<br>• Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral |
| **Referrals** | Referrals from "any person" or entity | Referrals from a physician |
| **Items/ Services** | Any items or services | Designated health services |
| **Intent** | Intent must be proven (knowing and willful) | No intent standard for overpayment (strict liability) |
| **Penalties** | **Criminal:**<br>• Fines up to $25,000 per violation<br>• Up to a 5 year prison term per violation<br><br>**Civil/Administrative:**<br>• False Claims Act liability<br>• Civil monetary penalties (CMP) and program exclusion<br>• Potential $50,000 CMP per violation<br>• Civil assessment of up to three times amount of kickback | **Civil:**<br>• Overpayment/refund obligation<br>• False Claims Act liability<br>• Civil monetary penalties (CMP) and program exclusion for knowing violations<br>• Potential $15,000 CMP for each service<br>• Civil assessment of up to three times the amount claimed |
| **Exceptions** | Voluntary safe harbors | Mandatory exceptions |
| **Federal Health Care Programs** | All | Medicare - Definitely<br>Medicaid - Maybe |

# Federal Healthcare Fraud & Abuse Laws

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**Criminal Health Care Fraud Statute**

Statute: 18 U.S.C. §§ 1347, 1349

**The False Claims Act**

Statute: 31 U.S.C. §§ 3729–3733

**The Anti-Kickback Statute**

Statute: 42 U.S.C. § 1320a–7b(b)

Safe Harbor Regulations: 42 C.F.R. § 1001.952

**The Physician Self-Referral Law (Stark Law)**

Statute: 42 U.S.C. § 1395nn

Regulations: 42 C.F.R. §§ 411.350–.389

# Federal Healthcare Fraud & Abuse Laws

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**The Civil Monetary Penalties Law**

Statute: 42 U.S.C. § 1320a–7a

Regulations: 42 C.F.R. pt. 1003

**Exclusion Authorities**

Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5

Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

# Questions?

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