A Fraud and Abuse Potpourri

NERVES

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April 13, 2007

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Overview

- Jim Sheehan’s view of life
- Who is liable when things go wrong?
- Other forms of liability based on quality
- Principles of compliance: a program not a plan
- The new permitted ‘gainsharing’ and quality
- A new reality and a new mindset

EACH WAY TO GET PAID IN HEALTH CARE HAS UNIQUE FRAUD RISKS- AND SOME COMMON ONES

- FEE FOR SERVICE RISKS
  - Services billed but not rendered
  - Medically unnecessary services
  - Double-billing
  - Services billed at higher level or with other inappropriate code to improperly obtain more reimbursement (upcoding, unbundling, evasion of global fees)
  - Kickbacks to other providers for patient referrals
  - kickbacks to patients to use more services

FEE FOR SERVICE MODEL CASES

- USA V. RUTGARD-CODING AND MEDICAL NECESSITY
- USA V. UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY-BOTH INDIVIDUAL PHYSICIANS AND UMDNJ BILLED AND PAID FOR SAME PHYSICIAN SERVICES
- USA V. GREBER-KICKBACKS TO REFERRING PHYSICIANS FOR PHYSICIAN ORDERS
- USA EX REL. LEE V. SMITHKLINE-BILLING FOR ORDERED BUT WORTHLESS TESTS
- PATH PROJECT- SERVICES PERFORMED BY RESIDENTS BILLED BY ATTENDING PHYSICIANS

WHAT IS THE QUALITY WE ARE PAYING FOR?

- 1) REDUCTION OF MEDICAL ERRORS/ADVERSE EVENTS
- 2) IMPROVEMENT IN OUTCOMES
- 3) COMPLIANCE WITH PRACTICE GUIDELINES OR REQUIREMENTS
- 4) REDUCTION IN COST FOR SAME OUTCOME

CORE QUESTION:WHY (AND WHEN) FRAUD ENFORCEMENT?

- KNOWING CONDUCT BY INSTITUTION/GROSS AND SYSTEMIC LEADERSHIP FAILURES (Notice, warning, failure to act)
- INTENTIONAL ACTS BY INDIVIDUALS
- FALSE REPORTING, FAILURE TO REPORT
- APPALLING OUTCOMES
- WHAT WILL BE CONSEQUENCES OF OUR INVOLVEMENT?

Who is Liable?

- The corporate entity if it got the money
- The billing company may be
- The provider always is unless there's no control over the person who did it
- The coder almost never is
- The manager could be

Exclusions Based on Quality Failures

- Items or services to patients (whether or not eligible for benefits under Medicare or Medicaid) substantially <u>in excess of the patient's needs</u> (42 USC 1320a-7(b)(6)(B))

- Of a <u>quality</u> which fails to meet professionally recognized standards of health care

Civil Money Penalties for Quality

- **Claims for a pattern of medical items or services that a person knows or should know are <u>not medically necessary</u> (42 USC 1320a-7a(a)(1)(E))**
- **Provides false or misleading information that could be expected to lead to <u>premature discharge</u> (42 USC 1320a-7a(a)(3))**
- **Hospital payments to physicians <u>to reduce services</u> (42 USC 1320a-7-a(b))**

Where Does Compliance Come From?

- Federal sentencing guidelines
- HIPAA impacts: “knew or should know”
  - Acts in deliberate ignorance of the truth or falsity of the claim
  - Acts in reckless disregard of the truth
  - No proof of specific intent is required
- Case law on intent
- Not everything is even an overpayment

How do they decide false claims liability?

- Notice to the provider?
- Clarity of the rule
- Pervasiveness and magnitude of the claims
- Is there a compliance plan
- Have they taken previous steps to rectify
- Has there been agency or program guidance
- Have there been prior audits
- Other information

The Quality/Compliance Nexus

- The point of compliance:
  - 1. Do it right.
  - 2. If you make a mess clean it up.
- Where compliance is today:
  - 1. eternal internal self-inspection and reporting
  - 2. ‘gotcha’
- Shifting the focus of compliance to reflect quality concerns with programmatic integration strengthens both (see AGG Note)

Principles of Compliance

- Be the little red hen
- Walk the walk: Don’t spawn whistleblowers
- Prioritize using the three questions:
  - What makes me think we are doing it right or wrong?
  - What will it take to fix it?
  - How will we know it stays fixed?

Seven Elements

- Standards and procedures (but it’s not what you write; it’s what you do)
- Specific individuals, high up, have responsibility: write in the active voice
- Use due care not to engage with those ‘with a propensity” to bad behavior: due diligence
- Communication and training

The Rest

- Monitor and audit over time and provide mechanisms to report (hot lines)
- Disciplinary mechanisms: the lipid nurse
- If ‘an offense’ is detected take steps to respond
  - Read the risk areas and the work plans

Can compliance really help you?

- Quality is job 1
- Even false claims issues relate to risk management which includes clinical risk management
- Related issues: utilization (med nec); antitrust (clin integration); privacy

Making a New Reality

- Review quality relevant enforcement challenges and get them into the compliance program
- Make use of Stark provision: 42 CFR 411.357(o)
- Think about the new ‘gainsharing’
- Practice UFT-A – use CPGs more
- Focus on medical necessity

Keep in mind

- Do you want it on the front page of the paper?
- What kind of snapshot will a prosecutor make of this in 30 seconds to a jury of people who haven’t graduated high school?
- What would your Mom say?
- Not asking doesn’t make it right
- Everyone does it doesn’t count
- Can you do better?

“Choose your own adventure”

Resources

- “The Quality/Compliance Nexus: Moving Toward Programmatic Integration”, AGG Note, July, 2003; http://www.gosfield.com/notes/index.hml
- "Legal Mandates for Physician Quality: Beyond Risk Management" HEALTH LAW HANDBOOK 2001 ed., West Group pp. 286-321