Learning Objectives

• Understand federal fraud and abuse laws and the importance of coders in avoiding issues.

• Understand ethical obligations in coding and documentation, and their significance to patient safety.

• Understand the components of medical malpractice litigation in Florida and exposure from coding acts or omissions.

Stark Law

Stark I: Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she or an immediate family member has a financial relationship, unless one of the exceptions applies.

Stark II: Prohibits the entity from representing claims to Medicare for those referred services.

Stark III: Establishes exceptions allowing financial relationships that do not pose a risk of program or patient abuse.
Designated Health Services (DHS)

- Clinical laboratory services
- Physical therapy services
- Occupation therapy services
- Radiology services
- Radiation therapy services
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospitalization services

Stark Penalties

- Denial of payment
- Refund to patient
- Monetary penalties up to $15,000/violation
- Exclusion from Medicare/Medicaid program
- Monetary penalties of $10,000/day for failing to report
- $100,000 monetary penalty for arranging scheme

Federal Anti-Kickback Statute (AKS)

Prohibits a person from knowingly and willfully offering, paying, soliciting, or receiving remuneration, whether directly or indirectly, to induce referrals of items or services covered by Medicare, Medicaid, or any other federally funded health care program.
Anti-Kickback Penalties

- Criminal fine up to $25,000
- Imprisonment up to 5 years
- Exclusion from federal programs with conviction
- Exclusion without conviction at discretion of HHS
- Civil damages up to $50,000 per violation

What is the False Claims Act?

"Lincoln Law" - enacted during Civil War to combat war profiteering

Provided for enhanced damages and penalties ($10,000 to $21,000 per claim plus treble damages which the Government sustains because of the false claim)

Provided that claims submitted in violation of "anti-kickback" violations were automatically considered False Claims Act violations

Federal False Claims Act

Covers arrangements between independent providers

Includes false or fraudulent claims for payment to any of the federal health care programs

Subject to a civil penalty of between $10,000 and $21,000 for each false claim
Types of FCA Violations

- Failing to report overpayments or credit balances
- Duplicate billing
- Billing wrong codes for services
- Billing for services not rendered / goods not provided
- Physician billing for services provided by interns, residents, etc.
- Falsifying treatment plans or medical records to maximize payments
- Financial arrangements with referrals
- Unlawful inducements in exchange for referrals
- Insufficient documentation of medical necessity or reasonableness
- Misstatements made in obtaining research grant monies
- Misrepresentation how federal research grant monies have been spent
- Implied certification

There Does Not Need To Be Specific Intent Of Wrongdoing To Be Subject To Sanction

Regulatory Enforcement Environment

Healthcare fraud enforcement activity has been increasing as the government seeks to reduce fraud and waste in the healthcare system.

False Claims Act lawsuits and fines/penalties are key drivers for government’s success.

DOJ has recovered more than $16.5 B since 2009 through FCA.

$1.97B was recovered in 2015 from healthcare fraud (out of $3.5B total recovery in settlements and judgments from fraud and FCA).

The cost to respond to billing investigations can be significant and include defense costs, forensic auditor fees, fines, penalties and other remedies

Qui Tam Litigation

Whistle-blower statute for violations of FCA

Anyone with knowledge about coding, billing or finances of provider

Protected from employer retaliation

May be awarded 15% to 25% of the funds recouped
FCA Settlement Examples

- Systematically discarding expensive dialysis drugs and billing the government for wasted drugs.
- Paying employed physicians bonuses based on referral volume and value and miscoding claims.
- Paying 7 employed physician assistants of HHS for services. Stark violation.
- Paying 7H4F compensation paid to medical director in violation of Stark and laws of adverse allegations.
- Paying cardiologists more than FMV for their services and bimakes for cardiology referrals.
- Filing outpatient surgical services performed at ambulatory surgery centers as performed as though performed in hospital’s outpatient department.
- Billing outpatient or observation services as more expensive inpatient services.
- Abuse that reports and other applications mistated information to increase reimbursement rates.
- Billing routine home care hospice claims as general inpatient care.
- Departing physicians who failed to provide total life management services.
- Submitting false and fraudulent claims for hospice services not rendered or inadequately provided.
- Submitting claims to Medicare for cardiac procedures not medically necessary.

Wyeth/Pfizer Fraudulent Pricing

- Fraud and Abuse recoveries by the DOJ and HHS in 2015 reported to be $2.4 billion. Drop from 2014 where recoveries were reported to be $3.3 billion.
- One of the largest reported recoveries involved $784.6 million from Wyeth and Pfizer related to underpayment of Medicaid drug rebates for two proton pump inhibitor drugs.
- Bundled sales arrangement if placed on formulary incentivized use
- Patients discharged on their drugs more likely to stay on it
- Medicaid was still charged the full price

Self-Disclosure

In 2016, self-disclosure cases resulted in payments from $10,000 to $3.7 million, relating to improper billing claims and practices.

Examples: procedures performed without a physician present or inappropriate payments for referrals.

From October 1, 2015 through July 14, 2016, there were 38 self-disclosures reported by the OIG involving employment of individuals that were excluded from participation in federal health care programs. The payments ranged from $10,000 to $807,856.65.

Continuing need to automate and increase the frequency of screening by organizations for excluded providers.
Coverage for Investigations

“Claim” to include government/commercial payer suits and investigations
Investigations will trigger coverage
Civil Fines and Penalties covered (no sub-limits)
Defense/Investigation costs
Attorneys’ costs
Forensic accountants, external auditors, billing and coding consultants, medical experts and other investigatory costs included
Actions by Commercial Payers covered

Culture of Compliance

Effective compliance program, compliance officer, and compliance committee
Established policies, procedures and standards of conduct
Effective training and education
Internal monitoring and auditing
Corrective action for detected offenses

International Considerations

Fraud and Abuse
• The practice of telemedicine across national boundaries presents additional fraud and abuse risks

Medicare Reimbursement Limitations
• Medicare currently places a ban on payment for services provided outside the United States

Immigration
• To the extent that services are rendered by physicians outside the United States or for the benefit of patients outside the United States, immigration issues must not be overlooked

Foreign Corrupt Practices Act (“FCPA”)
• Prohibits U.S. companies and individuals from paying bribes or kickbacks to a "foreign official" for the purpose of obtaining or retaining business
Liability Specific to Coders

Ethical Coding

Coding is one of the core health information management functions, and due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical challenges.

The AHIMA Standards of Ethical Coding are intended to assist coding professionals and managers in decision-making processes and actions, outline expectations for making ethical decisions in the workplace, and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported.

Upcoding

Falsely billing for a higher-priced treatment than was actually provided. Often this is accompanied by “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code.
Understanding Coder Liabilities

- Liabilities
- Incorrect Code Assignment
- Incorrect Reimbursement
- Privacy
- Security

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Established healthcare fraud as a federal criminal offense, with a basic crime carrying a federal prison term of 10 years in addition to significant financial penalties. (US Code, Title 18, Section 1347)

If that fraud result in the injury of a patient, the prison term can double, to 20 years; and if it results in the patient’s death, a perpetrator can be sentenced to life in federal prison.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

“Knowingly and willfully” attempt to defraud showing a pattern.

Two practices added to list of fraudulent activities:
1. Using code know/should know results in greater payment
2. Submitting claim know/should know is for item/service not medically necessary.

2000 cases in the Medicare fraud investigation database
### Know or Should Know

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<th>Know or Should Know</th>
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<td>Errors and difference of opinion are permitted</td>
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<tr>
<td>Coding/Billing practices published and disseminated to your facility</td>
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<tr>
<td>Issue is in official ICD/Coding Guidelines/Coding Clinic</td>
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<td>In the CPT Rules</td>
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### Risk Areas for Coding Fraud

- DRG assignment
- Unbundling (assigning separate codes for each component to increase reimbursement)
- Assigning a code for a higher level of service than the service actually provided
- Assigning a code for a "covered" service when the service actually provided is "non-covered"
- Assigning codes for diagnoses that are not present or for procedures that were not performed
- Discrepancies between the physician's and hospital's codes for the same patient visit

### Coder Liability

**Aiding and Abetting Example:**

Your supervisor comes to you and tells you that collections have been down since you were hired. You have been charging based on the documentation and not based on the charge ticket. Your supervisor says they will decided what code will be billed, rather than follow the documentation. To save your job, you agree.
Coded Liability

Accessory After the Fact Example:
Your supervisor asks you to hide the original patient charts while new ones are dictated, so the documentation will meet the code level billed.

Bayview Medical Center

In June 2009 John Hopkins’ Bayview Medical Center agreed to pay a $3 Million dollar settlement to settle the allegations of two medical coders who reported secondary diagnoses the physicians had not identified or treated.

NextCare

NextCare, a chain of urgent care facilities in several states, agreed to pay $10 Million to settle false claims acts. The company allegedly billed unnecessary allergy, H1N1 virus, and respiratory panel testing.

Settlement stemmed from a lawsuit originally filed by a former employee.
City of Dallas

The City of Dallas paid $2.47 Million to resolve a lawsuit under the False Claims Act and state law alleging that over a four year period the city upcoded ambulance transport claims submitted to Medicare and Medicaid.

Patient Safety

- Good documentation protects patient health
- Good documentation ensures the best possible care
- Good documentation prevents duplication
- Good documentation prevents unnecessary medical services
- Increased complexity requires more accurate medical records
Coding and Patient Safety

- Accurately assigning codes to identify complications of medical care
- Reducing costs of health care
- Medical coding provides the raw data required to analyze outcomes and costs, identifying trends, and develop best practices
- Hospital Acquired Conditions (HACs)

Medical Malpractice

Coding Issues Leading to Liability

- Failure to appropriately code can lead to errors in the medical record and negligent care
- The medical record is relied upon by all treaters to provide appropriate care
- Errors and misunderstandings in coding can follow the patient for years
A Legal Claim for Medical Negligence
May Include Allegations that:

• The patient was owed a DUTY of care that was not met.
• The prevailing STANDARD OF CARE was breached during the patient’s care.
• The breach in care was the PROXIMATE CAUSE of injury or death.
• The injury or death resulted DAMAGES.

Liability Protection

Professional liability is provided to Florida Board of Governors Self-Insurance Program Participants

Claims and Pre-Suit Process

• Events are investigated by SIP professional staff and analyzed for claim potential.
• In the Event a participant receives a Notice of Intent to Initiate a Medical Negligence filing, SIP will respond to the notice and manage the matter during the “pre-suit” process.
Claims and Litigation Process

Assuming the matter proceeds to a formal lawsuit being filed, SIP will manage the litigation including:

- Answering the complaint.
- Conducting and responding to discovery.
- Preparing and responding to motions.
- Employ expert witnesses.
- Participate in court ordered mediation, and if necessary.
- Prepare for and manage the trial of the case with the assistance of seasoned, highly experienced trial counsel.

THANK YOU