The False Claims Act and The Medical Staff Office: What you should know...

Session Code: TU10

Date: Tuesday, October 24

Time: 11:30 a.m. - 1:00 p.m.

Total CE Credits: 1.5

Presenter(s): Erin Muellenberg, JD
Overview

- False Claims Act
- Criminal and Civil Liability
- Conditions of Payment & Conditions of Participation
- Healthcare Enforcement
- United Memorial Hospital – Criminal Liability
- Redding Hospital – Unnecessary Services
- Azmat – Worthless Services
- Whistleblowers
- Compliance and the Medical Staff
- Case Studies
False Claims Act

- Enacted 1863
- Civil War supplies
  Thoroughbreds were ordered
False Claims Act

- *Knowingly* submitting False Claims for payment
  - “Claim” – any demand for payment

False Claims Act

- Knowledge of Falsity
  - Actual knowledge
  - Deliberate ignorance of the truth or falsity of the information
  - Reckless disregard of the truth or falsity of the information

Criminal v. Civil Liability
Federal Statutes with Criminal Liability
- The Anti-Kickback Statute 42 U.S.C. § 1320a-7b(b)
- The Health Insurance Portability and Accessibility Act, 42 U.S.C. § 1320d-6
- Federal All Payer Statutes: 18 U.S.C. §§ 1035 and 1347

Federal Statutes with Criminal Liability
- Mail and Wire Fraud: 18 U.S.C. §§ 1341 and 1343

Criminal & Civil Penalties
  - Amended in 2009 Fraud Enforcement and Recovery Act
- Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a
Penalties

- Penalties – Aug. 1, 2016 Interim Rule increase
  - $11,000 - $21,563 for each claim
  - Treble damages
  - Double damages in some circumstances for self-reporting

Conditions of Payment vs. Conditions of Participation

- Payment – Conditions which must be met to be paid
- Participation – Conditions which must be met to participate in a federal health care program

Medicare Attestation

- Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
  - 42 CFR 412.46(b)
Medicare Attestation

- Completion of acknowledgment. The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. **Existing acknowledgements signed by the physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.**
  
  42 CFR 424.16(c)

COP’s and the False Claims Act

- **Express Certification**
  - Complied with all Conditions of Payment

- **Implied Certification**
  - Complied with all Conditions of Payment and Participation

Expansion of False Claims Act Liability

- One year later –
  
  *Universal Health Services v. United States ex. rel. Escobar*
Escobar Underlying Facts

- Patient died from seizure after receiving mental health treatment
- UHS employed unlicensed and unsupervised personnel
- UHS billed for treatment
- Only one of five individuals treating decedent were properly licensed or supervised

Escobar Underlying Facts

- Counselors supervising decedent did not have license and not supervised
- Psychologist had application for licensure rejected
  » On-line unaccredited psychology course
  » Held herself out to be an experienced “doctor”
  » Prescribed medications without required supervision

Escobar Underlying Facts

- Decedent was allergic to the prescribed medication
- Counselor had fraudulently obtained NPI
- 22 additional employees had false NPIs as licensed mental health professionals
- No supervision
Submitting the Claims

Implied Certification

- Submitting claims = certifying compliance with all applicable laws and regulations
- Specific representations about the goods and services (e.g., reasonable & necessary)
- Representations must be “material” to government’s decision to pay

Healthcare Enforcement
Healthcare Fraud Enforcement is Alive and Well

- Cardiologist, Neurologist, and Others Charged in $50 Million Health Care Fraud Scheme, and Civil Suit Filed Against Clinic and Participants in the Fraud
- Defendants Provided False Patient Medical Information and Used the Identities of Doctors Who Did Not Work at the Clinic to Submit More Than $50 Million in Fraudulent Health Care Claims
- Defendants accessed hospital medical records to identify patients

www.justice.gov

March 1, 2017

24 Arrests in Arkansas

- The abuse of prescription medication, particularly opioids, is one of the largest health and crime problems Arkansas is facing,” Harris said. “This epidemic must be attacked on multiple fronts—by stopping the criminal doctors and medical professionals from writing medically unnecessary prescriptions,

- July 13, 2017

Pain Clinic

- Maryland doctor sentenced to 9 years and ordered to repay $3.9 million
  - Billed for image guided nerve blocks
  - Clinic did not own or use imaging guidance system
## Monetary Results: Total Transfers / Deposits by Recipient FY 2016

<table>
<thead>
<tr>
<th>Source of Revenue</th>
<th>Transfer / Deposit</th>
<th>Amount (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts and Bequests</td>
<td>Limited to Medicaid trust fund</td>
<td>$7,840</td>
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<tr>
<td>Amount Equal to Criminal Fines</td>
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<td>24,043,913</td>
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<td>Civil Monetary Penalties</td>
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<td>Asset Forfeiture</td>
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<td>Penalties and Multiple Damages</td>
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<td>HHS/OIG Audit Disallowances: Recovered</td>
<td>Medicare</td>
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<td>Restitution/Compensatory Damages*</td>
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<td><strong>Subtotal</strong></td>
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<td>734,271,149</td>
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<td><strong>Total Transferred to the Medicare Trust Funds</strong></td>
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<td>Restitution/Compensatory Damages to Federal Agencies</td>
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<td>HHS/OIG</td>
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<td>Office of Personnel Management</td>
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<td>National Institutes of Health</td>
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<td>Other Agencies</td>
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<td><strong>Subtotal</strong></td>
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<td>Centers for Medicare and Medicaid Services</td>
<td>Federal Share of Medicaid</td>
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<td>HHS/OIG Audit Disallowances: Recovered</td>
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<td><strong>Total</strong></td>
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<td>Relators’ Payments</td>
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<td>$529,965,605</td>
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<td><strong>GRAND TOTAL MONETARY RESULTS</strong>*</td>
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<td>$3,354,067,657</td>
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HEAT
Healthcare Fraud and Abuse Enforcement Team
- Mission
  » Prevent waste, fraud and abuse
  » “Crack down” on people and organizations
  » Reduce costs and improve care

Medicare Fraud Strikeforce
- Started in South Florida
- Focuses on data analysis to identify fraudulent billing
- Expanded to include
  - Los Angeles
  - Miami and Tampa
  - Chicago
  - Brooklyn, NY
  - Detroit
  - Southern Louisiana
  - Dallas
  - Southern Texas

Healthcare Fraud Prevention Partnership
- Public and private partnership
  » Federal Government, State Officials, law enforcement
  » Private health insurance plans and associations, anti-healthcare fraud associations
- Data exchange, research, consolidation, aggregation
- Fight fraud and abuse
  » Top billing pharmacies
  » Phantom providers
Recent Hospital FCA Settlements

- June 2017 – Pacific Alliance Medical Center, CA - $42 million – whistleblower claims of illegal referrals
- April 2017 – Norman Regional Health System, OK - $1.6 million – billing for radiology procedures without requisite physician supervision

Medical Necessity and the FCA

- Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services (1) (A) which, except for items and services described in a succeeding paragraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
Redding Hospital

➤ How Peer Review Failed at Redding Hospital
➤ A Congressional Report


Worthless Services

➤ “…the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all.”
➤ Mikes v. Straus (2001)

U.S. v. Azmat, Satilla Regional Medical Center

➤ “….services that were not reasonable and necessary, were incompatible with standards of acceptable medical practice, and were worthless and of no medical value.”
What Prompts an Investigation?

- Falsity
  - Misrepresentation, concealment or nondisclosure
  - Payment would not have been made if the true facts were known
- Knowledge
  - Actual knowledge, deliberate ignorance or reckless disregard
  - Provider billing for services knew or should have known they were not payable

REVIEW: Key Elements

- Falsity
- Knowledge
- DOJ Decision to Prosecute or Pursue
Red Flags

- Dept. chair selects all the cases for peer review
- Complaints of incompetence or unnecessary procedures are ignored
- High volume producers are not subjected to meaningful peer review
- Patients with significant deviations are not addressed
- Privileges are granted without documented evidence of competency

Avoiding Liability

Arthur S. Di Dio, M.D., M.D., Fraud Division DOJ

- Follow your bylaws
- Thorough credentialing
- Don’t ignore complaints!
- Take peer review/quality improvement seriously
  - Use external review when warranted
  - Review diagnostic testing to support procedures
Documenting Minutes

Your surgery committee has just reviewed the case of one of the busiest surgeons. The discussion was heated and you now have to write the minutes. You should write:

a. The committee concluded that the procedure was not indicated.
b. The committee concluded that there was insufficient documentation to support the indications for the procedure.
c. A member of the committee commented that the only reason the patient had the surgery was because he had good insurance.

Correspondence

The committee has asked you to draft a letter to the surgeon regarding the indications. You write:

a. You failed to document the indications for the procedure.
b. Documentation in the record must include the medical decision making process rather than just the medical decision.
c. Since you are the busiest surgeon in the hospital you don’t have to worry about the documentation.
d. You need to include copies of relevant diagnostic studies that support the performance of the procedure.

Follow-up

During the committee meeting you realize that the case with questionable indications belongs to the same surgeon who was placed on an FPPE for indications last year. You should:

a. Do nothing because it is none of your business.
b. Tell the chairperson that the physician has been under review previously.
c. Tell the committee they should summarily suspend the physician.
d. Recommend to the committee that they review past cases of the procedure.
Follow-up

When you get back to your office after the meeting you look at the surgeon’s credential file and see that over the last three years he has received nine letters asking about indications and six complaints from nurses about questionable indications. You should:

a. Do nothing and put the file away.
b. Notify the chairman and chief of staff
c. Pull together all the information regarding the cases and complaints to see if they involve the same procedure
d. Look up the number for a whistleblower attorney
e. Call the compliance officer
f. Review the bylaws to advise the medical staff officers on summary suspension

Clerical Error???

You have started a new job as the director of MSS at St. Elsewhere where you have taken over from a director who was respected, admired and now retired. You constantly hear how great she was from the doctors and other staff. During your first month on the job you receive a request for copies of Medicare attestation forms on seven doctors. You can only find two. When you audit the files you find that there are a total of 23 attestation forms missing.
After you stop hyperventilating you should:
   a. Polish up your resume and start looking for another job.
   b. Conduct a diligent search to see if the forms are anywhere else in the hospital.
   c. Take blank forms to the doctors and have them sign and back date them.
   d. Call the compliance officer.
   e. Call the retired director and ask what happened.
   f. All of the above
   g. None of the above
   h. Something else

Clerical Error????

After you polished up your resume you took a position at a 100 bed hospital with a medical staff of 200. After you started you found that there were several reappointment applications that had not been processed. In fact, seven of the members with unprocessed applications had expired appointments. You then started an audit and found that 29 practitioners had expired appointments and that approximately half had been expired over 18 months. One of the expired was the Chief of Staff.

After you pick yourself up off the floor, you should:
   a. Polish up your resume
   b. Immediately obtain temporary privileges for everyone who has expired
   c. Run patient care activity reports for the expiration period
   d. Back date all appointments and redo the minute
   e. Pour a glass of wine.
   f. Something else
Questions?