

## **Avoiding Fraud and Abuse Pitfalls**

### **Become familiar with laws and regulations to safeguard your practice.**

Without keeping abreast of laws, statutes, rules and the boundaries of state scope of practice regulations, providers can unknowingly commit violations that can devastate a practice. Some unwittingly trust that those they work for comply with all necessary legal requirements and later find themselves implicated for the violations of others.

Governmental agencies, payers and third-party investigators have increased efforts to address the problem of fraud, abuse and waste in both federal and private health care programs. Most recently, the Patient Protection and Affordable Care Act (PPACA) provides special provisions to halt waste, fraud and abuse in Medicare, Medicaid, CHIP and private insurance.

Providers regularly receive a myriad business offers that often make promises of earnings (such as entering into purchasing agreements for patient products or services) or include examples that would make instituting certain procedures (such as offering free services/supplies on one's Web site) appear to be acceptable practice. Such promotions create an environment in which all health care practitioners should be cautious.

Being alert by making a careful audit of the way health care services are provided, billed and advertised is essential to sound health care practice today. This issue particularly affects doctors of chiropractic due to the sheer number who are also small businesspersons—often without the benefit of a formal compliance department.

Over the years, the Office of the Inspector General (OIG) has issued fraud alerts as a mechanism to identify fraudulent and abusive practices within the health care industry. This article addresses, among others, the OIG view of certain practices such as waiving deductibles, offering discounts and inappropriate advertising, as well as the pertinent statutes and regulations on which the OIG bases its legal position. Also, Congress has broadly prohibited offering remuneration to Medicare and Medicaid beneficiaries, subject to limited, well-defined exceptions.

### **Federal Anti-Kickback Statute**

The federal anti-kickback law provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive payment in order to gain patient referrals and/or business, reimbursed under Medicare, Medicaid and other federally funded health programs. The criminal penalty for violation of the anti-kickback statute is a felony, which may result with imprisonment for up to five years, fines up to \$25,000, and/or exclusion from the Medicare/Medicaid and other federal health care programs. Civil monetary penalties may also be assessed at \$50,000 per violation and damages three times the remuneration involved.

For example, entering into an arrangement with a mobile diagnostics company or similar entity can put providers in jeopardy when the contractual arrangement violates Stark Laws<sup>1</sup> or the federal anti-kickback statute. See ACA's policy on mobile diagnostic services (available at [www.acatoday.org/policies](http://www.acatoday.org/policies)) for specific questions to help you assess whether an arrangement poses a problem. However, for specific contractual analysis, always consult your attorney, given the implications of the potential penalties.

### **Medicare and Medicaid False Claims Act<sup>2</sup>**

Federal law imposes criminal penalties for acts involving federal health care programs with up to five years imprisonment and fines up to \$25,000. Such acts include knowingly causing any false statement or false representation of material fact to be made in any claim or application for benefits under Medicare or Medicaid. Violations of this section include:

- billing for services not rendered
- misrepresenting services actually rendered, such as “up-coding” the level of a particular service
- offering payments or gifts to induce patients to come in for a consultation or treatment
- routinely waiving co-payments.

The government may also target any potential violation utilizing the Civil False Claims Act, which generally prohibits the presentation of “a false or fraudulent request for payment to the government.” Penalties for violation range between \$5,000 and \$10,000 per false claim, plus three times the amount of damages sustained by the government and also authorize private persons, i.e. “whistle blowers,” to bring an action in the name of the government.

### **Civil Monetary Penalties<sup>3</sup>**

The Civil Monetary Penalties law (CMP) gives the Secretary of HHS the ability to impose a civil penalty in relation to Medicare and Medicaid fraud and abuse. It is often the preferred method of enforcement officials to pursue fraud and abuse.

The following two practices, among others, can subject a doctor to civil monetary penalties of up to \$10,000 per line item or service, plus an assessment up to three times the amount claimed and result in an exclusion from Medicare, Medicaid or other federal health benefit programs.

- False or fraudulent claim. Any person who presents or causes to be presented a claim that the Secretary determines is for medical or other items or services that the person knows, or should know, was not provided as claimed, or the person knows or should know that the claim is false or fraudulent.
- Beneficiary inducements. The act establishes CMPs against organizations that provide remuneration to individuals which the organization knows or should know is reasonably likely to influence the individual's choice of provider, practitioner or supplier.

For example, waivers of co-payments and deductible amounts (or any part of these) and transfers of items or services for free or for other than fair market value would be considered as “reasonably likely to influence” the individual’s choice of provider.

According to the Office of the Inspector General, “offering valuable gifts to beneficiaries to influence their choice of a Medicare or Medicaid provider raises quality and cost concerns. Providers may have an economic incentive to offset the additional costs attributable to the giveaway by providing unnecessary services or by substituting cheaper or lower-quality services. The use of giveaways to attract business also favors large providers with greater financial resources for such activities, disadvantaging smaller providers and businesses.”

A recent bulletin from the National Medicare Training Program outlined some of the “dos and don’ts” of promotional activities. Below are some tips from the bulletin that are intended to assist providers when determining how best to promote their practices. This list, while mostly intended for Medicare Advantage Plan promotion, still gives a good summation of things to keep in mind when developing a marketing strategy, whether for Medicare or not.

<b>Providers Can</b>	<b>Providers Cannot</b>
Provide the names of plans which they contract and/or participate in	Direct, urge, or attempt to persuade any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor)
Provide information and assistance in applying for the low-income subsidy	Collect enrollment applications
Provide objective information on specific plan formularies, based on a particular patient’s medications and health care needs	Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
Provide objective information regarding specific plans, such as covered benefits, cost sharing and utilization management tools	Health screen when distributing information to patients, as health screening is a prohibited marketing activity
Distribute marketing materials, except for Medicare Advantage Plan enrollment application forms	Offer anything of value to induce plan enrollees to select them as their provider
Refer patients to other sources of information and share information from the CMS Web site	Expect compensation in consideration for the enrollment of a beneficiary
Use marketing materials comparing plan information created by a third party that doesn’t provide benefits or health care services	Expect compensation directly or indirectly from the plan for beneficiary enrollment activities
Display posters or other materials that advertise their relationship with the plans	
Help beneficiaries enroll in a plan that “best meets the beneficiaries’ needs”	

*References:*

1. 42 U.S.C.S. §1395nn] (§1877 of the Social Security Act) Also, regulations are at [42 C.F.R. §411.350 through §411.389]
  2. (42 U.S.C. § 1320a-7b(a))
  3. (42 U.S.C. § 1320a-7a)
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