

Do I REALLY Have To Do This?

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Fraud, Waste and Abuse and Compliance Training

- Lots of lingo, very complicated regulations.
- Plans say hospitals and clinics are “first tier downstream and related entities” (“FDR”).
- Plans may expect you to perform fraud, waste and abuse training and compliance training.
- They cite 42 C.F.R. 422.503 (b)(4)(vi)(C) and 423.504 (b)(4)(vi)(C).

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42 C.F.R. 422.503 (b)(4)(vi)(C)

(b) Conditions necessary to contract as an MA organization. Any entity seeking to contract as an MA organization must:

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following:

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:

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42 C.F.R. 422.503 (b)(4)(vi)(C)

(C) (1) Each MA organization must establish and implement effective training and education between the compliance officer and organization employees, the MA organization's chief executive or other senior administrator, managers and governing body members, and the MA organization's first tier, downstream, and related entities. Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member.

(2) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.

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42 C.F.R. 422.503 (b)(4)(vi)(C)

(3) An MA organization must require all of its first tier, downstream, and related entities to take the CMS training and accept the certificate of completion of the CMS training as satisfaction of this requirement. MA organizations are prohibited from developing and implementing their own training or providing supplemental training materials to fulfill this requirement.

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Things to Note

- Regulations refer to “the CMS training” without defining it.
- Regulations say Medicare suppliers and providers are exempt from FWA training.
- The reference to “CMS training” comes after this waiver.
- How does an “entity” train?

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General Compliance Training

Sponsors must ensure that general compliance information is communicated to their FDRs. The sponsor's compliance expectations can be communicated through distribution of the sponsor's Standards of Conduct and/or compliance policies and procedures to FDRs' employees. Distribution may be accomplished through Provider Guides, Business Associate Agreements or Participation Manuals, etc.

- Medicare Managed Care Manual Ch. 21 Sec. 50.3.1

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The Complication

- The Manuals haven't been updated since the regulations.
- The regulations and Manuals don't really apply directly to you.
- "Your contract controls!"

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Who "must" train?

In order to prevent unnecessary burden on FDRs, Sponsors should work with their FDRs and specify which positions within an FDR must complete the training. There will be certain FDRs where not every employee needs to take the training based on their duties.

Below are examples of the critical roles within an FDR that should clearly be required to fulfill the training requirements:

Positions/Roles

Senior administrators or managers directly responsible for the FDR's contract with the Sponsor (e.g. Senior Vice President, Departmental Managers, Chief Medical or Pharmacy Officer);

Individuals directly involved with establishing and administering the Sponsor's formulary and/or medical benefits coverage policies and procedures;

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Who “must” train?

Individuals involved with decision-making authority on behalf of the Sponsor (e.g. clinical decisions, coverage determinations, appeals and grievances, enrollment/disenrollment functions, processing of pharmacy or medical claims);

Reviewers of beneficiary claims and services submitted for payment; or,

Individuals with job functions that place the FDR in a position to commit significant noncompliance with CMS program requirements or health care FWA.

- CMS Memo; Additional Guidance – Compliance Program Training Requirements and Audit Process Update – December 28, 2015

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Do Medicare Rules Apply to MA Patients?

- No regulation expressly suggests this.
- Each program points a finger at the other.
- Review your payer agreement and provider manual.
- Stark may be a different story.

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Does the FCA Apply to Claims to MA Plans?

- Assume the answer is yes but ...
- Fight vigorously to argue the answer is no.

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Does the 60-Day Report and Return Provision Apply?

- It definitely applies to payments received by the plan from the government.
- Less clear whether it applies to payments from plans to providers and suppliers.
- Better safe than sorry?

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60 Day Rule: 42 CFR § 401.305(a)(2)

“A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.”

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What Is Knowingly?

“While we acknowledge the terms ‘knowing’ and ‘knowingly’ are defined but not otherwise used in Section 1128J(d) of the Act, we believe that Congress intended for Section 1128J(d) of the Act to apply broadly. If the requirement to report and return overpayments only applied to situations where the providers or suppliers had actual knowledge of the existence of an overpayment, then these entities could easily avoid returning improperly received payments and the purpose of the section would be defeated.”

- 81 FR 7660

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Is Six Years Right?

“*Overpayment* means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.”

- 42 CFR 401.303

- If the contractor can't reopen the claim, doesn't that mean you are entitled to keep the money?

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Six Years From When?

- Remember “identify” includes quantification.
- The six years runs from the date the overpayment is quantified not from the first suspicion of an overpayment.
- Operationally, this may be challenging.

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What Are Some Traps In The Episode Payment Model?

- “Related” care is bundled.
- Physician work, rehab, drugs, and hospital readmissions.
- What about hospice care??
- What about dirty bathrooms?

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Universal Health Services v. United States ex rel. Escobar

- Care by unlicensed “professionals”?
- Implied Certification case.
- Conditions of Payment v. Conditions of Participation?
- Opted for a materiality standard.

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Universal Health Services v. United States ex rel. Escobar

“Likewise, if the Government required contractors to aver their compliance with the entire U. S. Code and Code of Federal Regulations, then under this view, failing to mention noncompliance with any of those requirements would always be material. The False Claims Act does not adopt such an extraordinarily expansive view of liability.”

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Can I have different prices for different patients?

- One might argue every attendee has multiple charges for identical services.
- Beware of catchy phrases like “you can’t discriminate.”
- Inconsistent pricing for services isn’t “illegal”, but it may have collateral consequences.

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Can I have different prices for different patients?

- Note that Robinson-Patman prohibits price discrimination for goods.
- If you provide a discount to a cash paying walk-in, why is an auto insurer not entitled to the same rate?
- Many seemingly logical justifications run afoul of the law or your contracts.

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Can our group have different rates for different physicians?

- You CAN, the question is what will it mean.
- Unclear if U&C is by code or practitioner.
- If you bill as a group, probably best to assume it is by code.

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I have to give Medicare my lowest price, right?

- Wrong. Medicare pays the lower of:
 - actual charge.
 - fee schedule amount.
 - usual and customary charge.
- Usual and customary charge is defined as your median (50th percentile) charge.

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I have to give Medicaid my lowest price, right?

- Maybe. Depends on state law.
- In some states the “usual and customary” charge is defined as the charge that you charge most often.
- Some states follow Medicare.
- Some states require Medicaid to be the lowest.

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Can I require patients to pay more than their insurer reimburses?

- Do you have a contract with the insurer?
 - If yes, then you will need to review the contract.
 - If no, then you can charge the patient what you want.
 - Remember concepts of implied contract.

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Can I require patients to pay more than their insurer reimburses?

- What if the payor is Medicare?
 - If participating, then you must accept Medicare.
 - If nonparticipating, then limited by Medicare Limiting Charge (15% over Medicare’s approved amount).
 - If opted out, then do what you want.
- Medicaid – state by state.

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Can I charge a patient for “extras” like phone calls?

- Each payor has different rules.
- Medicare prohibits charging patients for covered services. Phone calls are “covered.”
- Most insurers include similar prohibitions in their contracts.
- Absent a contract, almost anything goes.

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Are coders personally liable?

- Almost never.
- Indemnification governed by state law, corporate documents.
 - Good faith.
 - Conduct legal.
 - Believe actions in company’s best interest.

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Can I adjust my fees to out-of-network patients to mirror the network?

- Extremely controversial issue.
- Insurers want the network to mean something.
- There may be no contract between you and the insurer, but there is a contract between the patient and the insurer.

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Can I adjust my fees to out-of-network patients to mirror the network?

- How the insurer reimburses out-of-network services may affect the analysis.
 - Fee schedule.
 - Percentage of charges.
 - Percentage of fee schedule.
- New Jersey court ruled against Health Net and for the physicians in an ASC dispute where ASC waived co-insurance. State law forbids dentists from waving co-insurance.

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Can we charge interest on outstanding balances?

- Payor/state law dependent.
- Know your contracts.
- Medicare claims the answer is no.
- Medicare's claim is wrong.

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Medicare cites:

"To collect only the difference between the Medicare approved amount and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under Sec. 410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100 percent of the approved amount."

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But interest isn't a charge for the service.

"The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly."

- MLN MM5613

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Can we charge interest on outstanding balances?

- Consider both federal and state law.
- Federal Truth in Lending Act.
 - Applies if you extend credit to patients.
 - Must make periodic disclosures.
- State usury laws.

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Can we provide free transportation to patients?

- OIG Advisory Opinions guide us.
- Good facts:
 - Modest transport; not limited to expensive treatments; not based on payor; no advertising; limited transportation alternatives; within historic service area; offered only to established patients; and individualized need determination (financial and medical).

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Can we provide free transportation to patients?

- “On-campus” is usually okay; what about “within the system”?
- Long distance plane rides seem to be blessed only in rare and extenuating circumstances.
- Transportation to and from patients’ homes feels risky.

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Can we give free care to Medicare recipients?

- Hospital requires EKG before surgery but denied by Medicare.
- Poor patient.
- Mad patient.

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Can we release medical records we received from a third party?

- Under HIPAA, “PHI” is any health information, created, received, or maintained by a covered entity.
- HIPAA lets a covered entity disclose PHI in a designated record set.
- Alcohol and drug abuse records protected by federal law should NOT be redisclosed.
- Remember state law considerations.

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Can we give prompt pay discounts?

- What rationale supports the discount?
 - insurance contracts prohibit “a billing fee.”
 - is it interest?
- I love my dentist.

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Is mailing a letter to the wrong patient a HIPAA Breach?

- Under the old “breach” definition, maybe not.
- New “breach” definition, breach is “presumed” and the information in most misaddressed letters is probably “compromised” if someone opens it.
- What if it was the mayor?

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Does HIPAA require us to encrypt PHI?

- The regulation says encryption is “addressable.” That means you have to be reasonable. Industry standards will determine what is reasonable.
- The guidance strongly recommends encryption.
- My unsolicited advice: encrypt laptops and devices that store PHI.

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Can we send emails to patients?

- Yes – there is no law preventing it.
- The new HIPAA rules changed the answer to the encryption question.
 - If a patient asks for a copy of his/her PHI, can send in an unencrypted email IF the patient consents to it after hearing about the risk. Document the conversation.
 - Advice: encrypt email to patients; check the address three times before sending.

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Can I share the legal advice I get with others?

- Risks waiving the privilege.
- May be able to use “common interest” privilege.
- Its validity is far from clear.
- Share at your own risk.

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Can physicians get credit for ordering ancillaries?


- Stark: Not for Medicare (Medicaid??)
- State law?
- Stark doesn't apply to private pay, but...
- How do you divide the revenue?
 - Equally.
 - Production.
 - Anything else that isn't who ordered it.

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Does Stark cover Medicaid?

- Darn good question.
- Some strong arguments it does not.
- This is not an area where we are inclined to tempt fate.

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Can we pay the exchange premium of a patient?

- K. Sebulius has said antikickback law doesn't apply.
- CMS has said they don't like the idea.
- Seems legal to us.
- Insurers may try to challenge it, but under what theory?

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How often do we have to check the OIG excluded list?

- There is no law that requires you to check.
- CMS's current position is that you must check the OIG List of Excluded Individuals and Entities monthly.
 - "New" Medicare Advantage manual language supports this.
- What about the System for Award Management ("SAM"), formerly GSA list?
- Watch out for attestations/certifications to payors.

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Can I give discounts to non-Medicare patients?

- It depends.
- Not if one purpose is to influence referrals.
- Beware of impact on Usual and Customary.
 - Medicare: Median Charge.
 - Medicaid: State defined.
 - Private Payors: Contractually defined.
- Need-based or complaint-based discounts probably fine.

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Is my consultant covered by the attorney/client privilege?

- Attorney/client privilege covers employees.
- Unless you have a broad state law definition of “employee,” your consultant probably isn’t covered.
- Only works if your attorney engages the consultant up front.
- Work product doctrine issues.

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Does the anti-markup rule apply to professional component?

- CMS says yes.
- They lack the legal authority to do so.
- Authorizing law is SSA 1861(s)(3). That law applies to diagnostic tests. Reads are physician services under 1861(s)(1).
- CMS knows this, but says that Congress’ omission was “inadvertent.”

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Do I have to use the OIG disclosure protocol to refund overpayments?

- This is a voluntary disclosure protocol.
- The OIG is the last place to raise a refund, except in certain special and rare circumstances.
- Report and return law says to go to the most appropriate entity (e.g., MAC, Medicaid agency, etc.)

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Must all charts be signed?

- Conditions of Participation will require it for most providers.
- Life is easier if the chart is signed.
- Payment shouldn't be denied for an unsigned chart.

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QUESTIONS?



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