

**Medical Billing Compliance
for
Federal Health Care Programs**

An Overview for the Physician Practice

MedAptus develops information technology solutions that connect physicians at the point of care with legacy medical information and billing systems. The company's charge capture application allows physicians to easily and accurately document diagnoses, procedures, and professional charges at the point of care. Once reviewed and approved, captured charges are directly submitted to the billing system. The system makes the billing process more efficient and accurate, helping ensure compliance with insurance regulations and improving practice reimbursement and cash flow.

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Introduction

Medical billing compliance has become and will continue to be an issue that commands the attention of health care professionals. The presence and perception of fraud and abuse within the U.S. health care system has caught the attention of the press, government agencies, and state and federal political leadership. Media coverage of investigations into violations of the *False Claims Act* and other federal laws has become commonplace and the attention has brought the topic into the public discourse as a law enforcement, public policy and political issue.

In Fiscal Year (FY) 1996, Medicare overpayments for health services were estimated at \$23.2 billion or 14% of total fee-for-service payments¹. Payments to physicians accounted for approximately 21.7 percent of the overpayments. Not surprisingly, the federal government has committed significant financial and other resources to addressing this issue.

- Federal funding to the Department of Justice (DOJ) and the Department of Health and Human Service (HHS) for investigation, prosecution and provider education has increased significantly each year since 1993.
- Civil actions and criminal prosecutions initiated by the DOJ have increased sharply.
- The DOJ has identified health care fraud as one of its top priorities.
- Coordination among government agencies involved in health care fraud investigation and prosecution is becoming increasingly sophisticated.

In submitting medical claims for payment, particularly to Medicare and Medicaid, providers should be aware of potential liability if those claims are deemed to be inappropriate or “fraudulent.” When paying a claim, the federal government has the authority to investigate the appropriateness of the claim and, if it finds fault, to impose significant financial and administrative penalties and/or pursue criminal prosecution of the offending party.

For the physician practice, these developments heighten the importance of developing effective systems to monitor their compliance with these myriad and evolving requirements. This comes at a time when physician practices are facing a trend of increased administrative costs and downward pressure on reimbursement. While the administrative cost and regulatory complexity may make this task appear daunting, the alternative is less attractive. This paper provides an overview of the relevant legislation, investigation and enforcement entities, and emerging government initiatives as they relate to physician practices.

¹ U.S. Department of Justice Health Care Fraud Report for FY 1998.

What Government Agencies are Involved in Enforcement?

Authority to conduct investigations and enforce the laws that apply to health care fraud and abuse generally resides with the Department of Justice, the Department of Health and Human Services or a combination of these agencies. Other official entities that may become involved in investigations include state Attorneys General, state Medicaid fraud control units, Medicare fiscal intermediaries and private insurance carriers. HHS includes the Office of the Inspector General (OIG) and the Health Care Financing Administration (HCFA). The DOJ includes the Federal Bureau of Investigation and the U.S. Attorney offices. The OIG and/or FBI are responsible for the investigations of fraud and development of cases for referral to United States Attorneys' offices for civil or criminal prosecution. The OIG, in conjunction with HCFA, also engages in fraud prevention initiatives including the development of provider education resources.

Table 1. Principal Agencies Involved in Medicare and Medicaid Fraud Prevention and Enforcement

Department of Health and Human Services	Department of Justice	State Authorities
Office of the Inspector General	U.S. Attorney offices	Attorneys General offices
Health Care Financing Administration	Federal Bureau of Investigation	State Medicaid fraud control unit

Overview of Fraud and Abuse Laws

The law provides criminal and civil penalties for fraud and abuse against Medicare and Medicaid. Medicare fraud usually takes the form of false claims submitted to carriers and intermediaries for medical or health services that, in fact, were not rendered. Another form of fraud is the representation on a Medicare claim form of more complicated and hence, more costly, procedures than those actually rendered. Yet another form of Medicare fraud results from “kickback” arrangements between providers of services and their suppliers.

The terms “fraud” is defined in the Medicare Carrier Manual as follows:

“Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another.”²

² Medicare Carrier Manual.

Medicaid regulatory provisions define the term “abuse” as follows:

“Provider practices that are inconsistent with sound fiscal, business or medical practices, resulting either in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care.”³

Medicare fraud usually takes the form of submitting false claims for medical or health services. Although this by no means represents a comprehensive list of fraud and abuse laws, the following are those most widely used to prosecute incidents of wrongdoing:

- The False Claims Act (includes *qui tam* actions)
- Civil Monetary Penalties Law
- Limitation on Certain Physician Referrals (“Stark Laws”)
- The Criminal False Claims Act
- Anti-Kickback Statute

Civil Statutes

The False Claims Act (31 U.S. Code §§3729-33)

The False Claims Act is the primary enforcement tool employed by the government to combat fraud and abuse by health care providers. This act prohibits “knowingly” presenting (or causing to be presented) a false claim to the Federal Government for payment or approval. Violations of the Act are prosecuted by the U.S. Attorney’s office of the DOJ. A “false claim” under this statute is defined as follows:

“A false claim is a claim for payment for services or supplies that were not provided specifically as presented or for which the provider is otherwise not entitled to payment.”⁴

It is also important to understand that, as it relates to this statute, the term “knowingly” includes actual knowledge, acts in deliberate ignorance of the truth or falsity of the information on the claim, or acts in reckless disregard for the truth or falsity of the information. In other words, the provider does not need to intend to deceive the government for a medical claim to meet the criteria of fraud under this statute.

³ 42 CFR §455.2 Definitions

⁴ The False Claims Act (31 U.S. Code §§3729 - 33)

Penalties for violation of The False Claims Act can be significant and include liability for damages of up to three times the amount unlawfully claimed plus a minimum of \$5,000 and maximum of \$10,000 for each false claim submitted.⁵

“...the provider does not need to intend to deceive the government for a medical claim to meet the criteria of fraud under this statute.”

The False Claims Act also includes *qui tam* or “whistleblower” provisions that allow for private citizens to initiate lawsuits on behalf of the Federal Government for violation of the Act by referring cases to

the DOJ. Under the *qui tam* provisions the whistleblower or “relator” can receive between 10 and 25 percent of the proceeds from any judgments depending on the level of the individual’s contribution.⁶ In 1999 alone payments to relators were in excess of \$44 million.⁷

Civil Monetary Penalties Law (42 U.S. Code §§1320a-27a)

This Civil Monetary Penalties Law (CMPL) provides the Secretary of Health and Human Services the authority to *administratively* impose civil money penalties and assessments against a person or organization for making false or otherwise improper claims against any federal health care program. The fraudulent activities covered under this statute are similar to those addressed in the False Claims Act. However, since they are administratively imposed, penalties may be made in lieu of, or in addition to criminal proceeding brought by the DOJ.

The Secretary may assess penalties of up to \$10,000 and up to three times the amount unlawfully claimed for each violation of the CMPL. Providers who are found to repeatedly violate the CMPL may be suspended from participation in the Medicare and Medicaid programs.

“Stark Laws” (42 U.S. Code §1395)

These laws prohibit physicians from referring Medicare or Medicaid patients to an organization in which they have a financial interest and will benefit from payments made by the Federal plan. The law includes notable exceptions to these prohibitions such as services that will be provided by the physician issuing the referral and in-office ancillary services.

Penalties for violation of the statute can include a civil monetary of up to \$15,000 per claim and up to \$100,000 per “arrangement” that circumvents the referral restriction.

Criminal Statutes

Criminal False Claims Act (18 U.S. Code)

Prior to the passage of the Health Insurance Portability and Accountability Act (HIPPA) in 1996, the provisions of the Federal criminal false claims laws did not specifically apply to the health care industry. However, HIPPA amended the criminal code to include federal health care offenses as “violations of, or conspiracies to violate” certain sections of this law.

⁵ OIG Compliance Program for Individual and Small Group Practices

⁶ 31 U.S. Code §3730

⁷ HHS and DOJ Health Care Fraud and Abuse Control Program Annual Report for FY 1999

The HIPAA amendments include:

- Theft or Embezzlement - 18 U.S. Code §669
- False Statements Relating to Health Care Matters - 18 U.S. Code §1035
- Health Care Fraud - 18 U.S. Code §1347
- Obstruction of Criminal Investigations of Health Care Offenses - 18 U.S. Code §1518

Penalties vary by statute, but include maximum prison sentences of 5 to 20 years, imposition of fines of between \$1,000 and \$10,000, or both.

Anti-Kickback Statute (42 U.S. Code §1320a-7b)

Under this statute it is a crime to “knowingly and willfully” solicit, receive or offer any remuneration (including any kickback, bribe or rebate) to induce referral or the purchase of services for which a claim for payment is made to a Federal health plan. The statute also includes provisions for exceptions to these prohibitions (“Safe Harbors”) to be established by the OIG. A complete listing of these exceptions can be found at www.hhs.gov/oig/ak.

Violations of this statute are punishable by imprisonment for up to 5 years, a fine of up to \$25,000 or both.

Government Activities to Reduce Health Care Fraud

Over the past six years the government has pursued aggressive strategies to fight “fraud, waste and abuse in Medicare and Medicaid.” In general, the strategies have included enhanced funding, coordination among the various administrative and enforcement arms of the government and increased criminal penalties and fines. These efforts have yielded significant financial and political results and their expansion is not likely to slow in the near future. Some of the major initiatives are described below.

Operation Restore Trust (ORT)

In May 1995, Secretary of HHS Donna Shalala launched ORT as a two-year demonstration project in five states designed to coordinate the activities of the OIG with HCFA and other HHS departments in identifying and preventing fraud. During its first two years, ORT was credited with the identification of \$23 in overpayments for every \$1 spent. The initiative has since been renewed and expanded nationally.⁸

Health Insurance Portability and Accountability Act of 1996

HIPPA legislation included several significant provisions designed to expand existing anti-fraud programs and laws, provide a stable funding source for those programs and coordinate the activities among government agencies involved in anti-fraud activities. Selected provisions are described below.

⁸ The Clinton Administration’s Comprehensive Strategy to Fight Health Care Fraud, Waste and Abuse - March 16, 1998

Health Care Fraud and Abuse Program

HIPAA creates a national fraud and abuse program to coordinate federal, state and local law enforcement efforts. The program reports jointly to HHS (OIG office) and the DOJ. The combined anti-fraud efforts of this program resulted in \$490 million in judgments and settlements collected from health care providers in 1999 up from \$296 million in 1998. During that time over 6,000 providers were excluded from participation in Federal health care programs.⁹

Guaranteed and Expanded Funding

The Act also establishes a Health Care Fraud and Abuse Account into which fines and penalties collected by the coordinated health care fraud and abuse programs are deposited. The Secretary of HHS and Attorney General may allocate a portion of these funds for the costs they certify as necessary for related program activities. In 1997 (the first year of this program), \$104 million in discretionary funding was allocated from this account for the anti-fraud initiatives of HHS and DOJ under the Health Care Fraud and Abuse Program. By 1999, funding had increased 32 percent.¹⁰

Table 2. Discretionary Funding by Year (Millions)

Agency	1997	1998	1999
Health and Human Services	\$82	\$91	\$106
Department of Justice	22	28	31
Total Funding	\$104	\$119	\$137

Medicare Integrity Program

This program requires HHS (through HCFA) to establish an Integrity Program with the goal of identifying and reducing Medicare “overpayments” through a combination of reviewing and auditing provider claim and cost report data, identifying plan beneficiaries with additional insurance and provider education initiatives. These initiatives returned \$14 for every \$1 spent and saved an estimated \$7.5 billion in 1997.¹¹ In FY 2001 HCFA will receive \$680 million for these initiatives (up from \$630 million) and will begin contracting with private entities (Program Integrity Contractors) to expand the scope of the program.¹²

Expanded Civil and Criminal Penalties for Fraud and Abuse Violations:

HIPAA expands and/or increases the penalties for many existing statutes related to health care fraud and abuse. These changes are reflected in the Overview of Fraud and Abuse Laws section above.

⁹ HHS and DOJ Health Care Fraud and Abuse Control Program Annual Reports for FY 1998 and FY 1999.

¹⁰ HHS and DOJ Health Care Fraud and Abuse Control Program Annual Reports for FY 1998 and FY 1999.

⁶ The Clinton Administration’s Comprehensive Strategy to Fight Health Care Fraud, Waste and Abuse - March 16, 1998.

¹² HCFA Fact Sheet - Fighting Fraud, Waste and Abuse in Medicare and Medicaid. April 2000.

Correct Coding Initiative

In 1994 HCFA developed a program to detect improperly coded claims, or services that should be grouped together and paid as one item at a lower rate than if billed separately. The system, known as the Correct Coding Initiative, was first implemented in 1996. It includes some 93,000 computer edits and saved almost \$260 million in FY 1997.¹³

Development of Voluntary Compliance Guidelines

Over the past several years the OIG has developed compliance guidelines for various segments of the health care industry to promote provider education and reduce fraud. These are discussed further in the section that follows.

Expansion of DOJ Staff Resources Devoted to Health Care Fraud

Since 1993 the DOJ has significantly increased the number of prosecutors and FBI agents devoted to combating health care fraud.

Table 3. FTEs Devoted to Health Care Fraud¹⁴

Fiscal Year	US Attorney Offices Attorneys	Civil Division Attorneys	Criminal Division Attorneys	FBI Agents
1993	43	6	3	147
1994	71	10	3	225
1995	85	13	3	261
1996	93	11	3	256
1997	132	17	7	395
1998	185	40	7	442

¹³ Statement of Nancy-Ann DeParle, Administrator of HCFA, before the Subcommittee on Oversight and Investigations of the House Committee on Commerce, May 19, 1998.

¹⁴ Department of Justice Health Care Fraud Report for FY 1998.

How Can Physician Practices Reduce Their Risk?

At the same time that the government has been committing increased resources to the investigation and prosecution of health care fraud, they have begun emphasizing the importance of providers developing their own compliance programs to identify and prevent fraud. To this end:

- The OIG has developed eight “voluntary” compliance program guidelines, each focused on different segments of the health care industry.
- Every settlement entered into by the DOJ has included some provisions addressing compliance procedures.
- Criminal and civil penalties imposed against providers with “effective” compliance programs are less severe.¹⁵

Focus First on OIG- Identified High Risk Areas

Additionally, the OIG has identified what it believes are “particularly problematic” fraud and abuse risk areas on which physician practices may wish to focus their compliance efforts. Among those identified are the following.¹⁶

- Coding and Billing - (e.g., upcoding or failing to properly use modifiers)
- Reasonableness and Necessity of Services (e.g., providing services that are not justified by the diagnosis and/or documentation).
- Documentation of Services Provided (e.g., billing for services not actually documented)
- Improper Inducements, Kickback and Self-referrals

Implement A Practice Compliance Program

The OIG has developed eight “voluntary” compliance program guidelines, each focused on different segments of the health care industry. Two of these are guidelines apply to physician billing practices, copies of which can be found on the HHS Web site at www.hhs.gov/oig/modcomp/index.htm.

- *Compliance Program Guidance for Third-Party Medical Billing Companies* (intended for larger physician practices and billing companies - November, 1998)
- *OIG Compliance Program for Individual and Small Group Physician Practices* (September, 2000)

¹⁵ Open letter from the Inspector General to the Health Care Community; Urges Providers to Self-Disclose Improper Conduct. Federal Sentencing Guideline Manual §8C2.5(f).

¹⁶ OIG Compliance Program for Individual and Small Group Practices and Compliance Program Guidance for Third-Party Medical Billing Companies.

Elements of a Compliance Program

These plans differ in the complexity, scope and size of the recommended approach for ensuring compliance, but promote the same set of seven elements that should be included within a compliance plan. These elements are based on the Sentencing Guideline Manual which states that at a minimum, a comprehensive compliance program should include:

1. The development and distribution of written standards of conduct.
2. The designation of a Chief Compliance Officer and other appropriate bodies.
3. The development and implementation of regular, effective education and training programs for all affected employees.
4. The creation and maintenance of a process to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect them from retaliation.
5. The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against offenders.
6. The use of audits and/or other risk evaluation techniques to monitor compliance.
7. The investigation and correction of identified systemic problems and the development of policies addressing the non-employment of sanctioned individuals.

Decreased Penalties With Compliance Plan

In the event of an OIG audit, or the discovery of fraudulent billing activities, the presence of an effective compliance program can significantly mitigate the penalties imposed.

- In criminal cases, the Federal Sentencing Guidelines mandate decreased monetary penalties and length of imprisonment if the offending party has an “effective” compliance program in place prior to the occurrence of the offense.¹⁷
- The OIG, for example, will consider the existence of an effective compliance program that pre-dates any governmental investigation when addressing the appropriateness of administrative sanctions.¹⁸
- The False Claims Act, 31 U.S.C. §§ 3729-3733, provides that a person who has violated the Act, but who voluntarily discloses the violation to the Government within thirty days of detection, in certain circumstances will be subject to not less than double, as opposed to treble, damages. Thus, the ability to react quickly when violations are discovered may materially help reduce liability.

¹⁷ Federal Sentencing Guideline Manual - Sentencing for Organizations §8C2.5(f).

¹⁸ OIG Compliance Program Guidance for Third-Party Medical Billing Companies.

While what constitutes an “effective” compliance program remains undefined, the guidelines issued by the OIG provide the clearest and most defensible strategy for meeting this standard.

Conclusion

An effective compliance program and systems to ensure accurate coding are important tools that can help a physician practice avoid or cope with an audit of billing activities. In the absence of such tools, some physicians may respond by defensively down-coding. This approach has several shortcomings. It leaves the practice at risk of an audit and exposed to the maximum penalties levied against practices without a compliance program. Furthermore, failure to completely and accurately code results in lower levels of reimbursement than the practice has fairly earned.

Increases in government resources devoted to this issue make the possibility of a Government review of practice billing activity more likely, even for smaller groups. The use of computers to scrutinize claims to identify possible incidents of fraud, coupled with increased numbers of investigators and prosecutors expand the reach of Government in this area.

While the task of developing and implementing an effective program to monitor compliance may appear daunting, the consequences of failing to do so can be dire. It is important for physician practices remain informed of their obligation in submitting claims for payment, particularly those to the Government. The law does not require that a physician intend to deceive the Government for a medical claim to meet the criteria for fraud. Ignorance of the law can also result the initiation of civil or, in some cases, criminal action against the physician.

Selected compliance Resources Available on the Internet

Health Care Compliance Association: www.hcca-info.org/html/resources.html

OIG Electronic Reading Room: www.hhs.gov/oig/readrm/index.htm

CCH Incorporated: www.health.cch.com

United States Department of Justice: www.usdoj.gov

Health Care Financing Administration: www.hcfa.gov/

Medical Group Management Association: www.mgma.com

Association of American Medical Colleges: <http://www.aamc.org/>

American Medical Association: www.ama-assn.com