“So, you got a letter in the mail…”
Steps to take when facing an audit

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Assumptions and Disclaimers for this Presentation

• Since this audience is the American Academy of Professional Coders (AAPC), we will assume:

  1. You are familiar with the Centers for Medicare and Medicaid (CMS).
  2. You are familiar with the Florida Agency for Healthcare Administration (AHCA).
  3. You are familiar with the Medicare Administrative Contractors (MACs) (such as First Coast, etc.) that serve on behalf of the government in processing government health program claims.
  4. You are familiar with Unified Program Integrity Contractors (UPICs) (Such as Safeguard, etc.)
  5. Legal Disclaimer*

*Legal Disclaimer: By providing these assumptions and disclaimers, the presenter acknowledges that the information presented is intended for educational purposes only and does not constitute legal advice. Any specific questions or issues should be addressed with legal counsel familiar with the relevant laws and regulations.
So, the first question regarding an audit letter is...

• Why is your organization receiving this letter?
  – Is it from a 3-letter agency like CMS, DOJ, OIG, etc.?
  – Is it from a 4-letter agency like AHCA?
  – Is it from a MAC or UPIC?
  – Is it from a private-payer insurance company?

• The likely reason your organization is receiving this letter is because these agencies or government contractors are checking to see if your organization is COMPLYING WITH THE LAW (and corresponding regulations).

• Why? It could be a random audit, or it could be a whistleblower that filed a complaint, or it could be a referral from another government agency, etc.
Why? Because in the provision of healthcare there are many, many laws and regulations (Federal) to COMPLY with...

- **18 U.S. Code § 1347 - Health care fraud**
- It applies to any public or **private plan** or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.
- **31 U.S. Code § 3729 - False claims** (False Claims Act)
- **42 U.S. Code § 1320a–7b(B) - Criminal penalties for acts involving Federal health care programs** (Anti-Kickback Statute)
- **42 U.S. Code § 1395nn - Limitation on certain physician referrals** (Stark Law)
- **Medicare "Program Integrity Manual", Pub 100-08, Chapter 3, Section 3.2.3 A.** (Medical Necessity Documentation)
South Miami Hospital to pay $12M to Settle False Claims Act Allegations

• On December 7, 2016 the U.S. Attorney’s Office, Southern District of Florida, along with a team of investigators from HHS, the Defense Criminal Investigation Service (DCIS) and the Office of Personnel Management (OPM) announced the settlement.

• South Miami Hospital settled allegations that it had violated the FCA by submitting false claims to multiple federal health care programs for medically unnecessary heart procedures by Dr. John R. Dylewski.

• Suit was brought under qui tam provisions of the FCA by two whistleblowers.

• The two physicians claimed to have personal knowledge of Dr. Dylewski and the hospital performing a number of unnecessary cardiac procedures.

• Procedures were performed for the sole purpose of increasing reimbursements from Medicare and other federally-funded healthcare programs.
Southeast Orthopedics Specialists Agree to $4.49M Settlement in False Claims

- The U.S. Attorney’s Office, Middle District of Florida announced in December, 2016 that Southeast Orthopedic Specialists (SOS) agreed to pay $4.49M to resolve allegations that the medical group had violated the False Claims Act (FCA) by seeking reimbursement for services not “medically necessary” and reasonable.
- The U.S. alleges the questionable bills include knowingly billing for: Certified that certain standards related to the “meaningful use” of electronic health records were met, when in fact they were not.
- Certain claims as “incident to” physician supervision when none was present (Note: these are different in Florida under Medicare and Medicaid) or no verification of a physician being present.
- Certain claims using Coding Modifier 25 signifying that a separate evaluation & management service was performed, when there was no separate service.
- Certain claims using Coding Modifier 59 signifying two procedures (rather than one) were billable, when the procedures should have appropriately been billed as one.
- Scheduling patient follow-up appointments 12-14 weeks post op in an effort to circumvent Medicare’s 90-day diagnosis-related group charge.
- Ultrasound-guided injections were provided routinely in the absence of medical necessity.
- Certain physical therapy claims using Coding Modifier KX to exceed the Medicare cap, in the absence of medical necessity.
Florida-based 21st Century Oncology and Physicians Involved in Multiple Settlements

- Four physicians named in settlement between 21st Century Oncology and the U.S. government, a case which resulted in a tip from a whistleblower. Dr. Spellberg’s former medical assistant was fired after raising concerns about testing practices.

- **December 2015 - 21st Century Oncology** agreed to pay $19.75M to settle these FCA violation allegations:
  - Billing medically unnecessary lab urine tests (FISH)
  - Paid bonuses to physicians in part by encouraging them to order these tests

- **January 2016 - Dr. David Spellberg** agreed to pay $1.05M to settle allegations that he violated the FCA by causing claims to be submitted to federal health care programs for medically unnecessary lab tests.

- **March 2016 - 21st Century Oncology** agreed to pay nearly $34.7M to settle these FCA violation allegations:
  - Performed and billed for medically unnecessary procedures (Gamma Function)
  - Defendants billed for procedure when results were not reviewed by a physician in timely manner
  - Defendants billed for procedure when no result was available due to technical failures

- **August 2016 - Dr. Robert Scappa** agreed to pay $250K to settle allegations that he violated the FCA by causing claims to be submitted to federal health care programs for medically unnecessary lab tests

- **February 2017 - Dr. Meir Daller** agreed to pay $3.81M to settle allegations that he violated the FCA by causing claims to be submitted to federal health care programs for medically unnecessary lab tests

- To date there is no settlement on record with Dr. Steven Paletsky.
United States ex. rel. Baklid-Kunz v. Halifax Medical Center

- Halifax Hospital is in Daytona Beach, Florida
- In 2014, it paid $86M to settle alleged Stark Law and Anti-Kickback violations, brought by a qui tam Relator.
  - The Relator was the actual Halifax compliance officer turned whistleblower.
- The government alleged that the prohibited referrals, upcoding, etc. resulted in the submission of 74,838 claims and overpayments of over $100M dollars.
42 U.S. Code § 1320a–7 - Exclusion of certain individuals and entities from participation in Medicare and State health care programs

• The Office of Inspector General (OIG) was established in the U.S. Department of Health and Human Services (HHS) to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in Departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections, and investigations.

• In addition, the OIG has been given the authority to exclude from participation in Medicare, Medicaid and other Federal health care programs individuals and entities who have engaged in fraud or abuse, and to impose civil money penalties (CMPs) for certain misconduct related to Federal health care programs (per sections 1128 and 1156 of the Social Security Act).
There are two categories of OIG exclusions

• Mandatory Exclusions:
  – Federal Health Program (Medicare or Medicaid) fraud.
  – Patient abuse or neglect.
  – Felony convictions for other healthcare-related fraud, theft, or financial misconduct (tax evasion, etc.).
  – Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances.
There are two categories of OIG exclusions

• **Permissive Exclusions**: are based on sanctions by other government agencies, such as state medical boards, or by provider misconduct including defaulting on health education loans or providing unnecessary or deficient care.
  – Excluded providers may not bill Medicare or Medicaid, nor may their services be billed indirectly through an employer or group practice.
  – Employers are responsible for screening professionals and staff for OIG exclusion status.
    – [https://exclusions.oig.hhs.gov/](https://exclusions.oig.hhs.gov/)

• It is important to note, that right from the beginning the MAC contractors have a lot of legal power in making these decisions.
42 U.S. Code § 1320a–7a - Civil monetary penalties

- The OIG may seek civil monetary penalties for a wide variety of misconduct, including presenting a claim that is false or fraudulent because it is for a “medically unnecessary” procedure.
  – Note: This is why proper/accurate coding and documentation is very important!

- The OIG may also impose penalties for violating the Medicare assignment agreement (all updates usually have to be made within 30-90 days depending) by overcharging or double billing Medicare patients.

- The penalties range from $10,000 to $50,000 per violation.
Examples of violations that can incur civil-monetary penalties are:

- Violations of the False Claims Act or Anti-kickback Statute.
- Violating the Medicare physician agreement.
- Providing false or misleading information expected to influence a decision to discharge.
- Failing to provide adequate medical screening for patients who present to a hospital emergency department with an emergency medical condition or in labor.
- Making false statements (omissions) or misrepresentations on applications or contracts to participate in federal health care programs.
But there are also many, many Florida “State” laws and regulations to COMPLY with as well...

And, so how do you efficiently and effectively “comply” with all of these laws and regulations?

Through a properly planned, resourced, and executed:

“COMPLI”-ANCE PROGRAM
Daniel Levinson, Inspector General, Office of the HHS Inspector General (OIG), stated at the 2009 Compliance Institute, Las Vegas, NV (10 years ago)

“We expect that every health care provider will have an effective compliance program.”
So, every healthcare provider needs an effective compliance program....

But, when do you really need one?

Basically, before you ever get a “four-letter” Agency letter in the mail....
There are Seven Elements of an Effective Healthcare Compliance Program

“An ounce of compliance program prevention is worth more than a pound of legal cure”
The 7 elements of an effective healthcare compliance program

1. Conducting internal monitoring and auditing through the performance of periodic audits.

2. Implementing compliance and practice standards through the development of written standards and procedures.

3. Designating a compliance officer to monitor compliance efforts and enforce practice standards.

4. Conducting appropriate training and education on practice standards and procedures.

5. Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities.

6. Developing open-lines of communication to keep practice employees updated regarding compliance activities. No retaliation policy.

7. Enforcing disciplinary standards through well-publicized guidelines.
Based on the size and scale of your organization, you can source these 7 compliance functions with in-house personnel or out-source them (or do it with a combination of both).
Where to Start?

– The OIG’s Compliance Guidance:
  
  
  • OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.

– AHCA’s Medicaid Quality and Clinical Compliance Monitoring:
  
  
Creating a Healthcare Compliance Program

• Identify High Risk Areas: Medical Necessity
  – According to the law, in order for expenses incurred for items or services to be covered by Medicare, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."
  – CMS defines medical necessity as: “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of you or your doctor.”
Other Risk Areas

• Billing and Coding
• Medical Record Documentation
• HIPAA
• EMR operation
• HCFA 1500 Form documentation
• Provider Credentials
• Fair Market Value (FMV)
• A high turnover of personnel, especially certified-coders
Need to Develop a Compliance Plan

• Q: What if you don’t have a compliance program right now, or based on what I have covered so far, you believe the compliance program you have may be insufficient?

• A: The practice needs to make sure they know what “right looks like” as soon as possible.

• Why? Because if you are billing Medicare, Medicaid, or Private Insurance, it is not a question of “IF” an audit letter will come in the mail; the more relevant question is “WHEN” is that audit letter coming?
Need to Develop a Compliance Plan

• A: More importantly, under the Federal Sentencing Guidelines, a compliance program can serve as a significant mitigating factor when the government wants to impose penalties.

• A: In some cases, based on its sufficiency, it can even prevent the government from taking action.

• A: Also, if you are indicted and the government is going to issue a penalty, a sufficient compliance program can reduce time off of the sentence.
Proper coding is one of the keys to being compliant with the law and corresponding regulations

• Actions regarding coding compliance as part of an overall compliance program should include:
  – Conducting a full, baseline assessment of the organization’s coding efficiency and accuracy.
  – Training all providers, starting with a baseline training session to ensure knowledge of the current compliance rules and documentation guidelines.
  – Certification of provider coding accuracy.
  – Additional education for providers who fall below established quality and accuracy benchmarks.
  – Don’t be afraid to bring in an expert.
Audit Examples

• What if today (after this talk) you believe your organization does not have a sufficient compliance program?

• We will use a couple of constructs to present compliance actions to take if your organization receives a letter in the mail.
  – The AHCA year-long moratorium on the enrollment of new South Florida Behavior Analysis providers.
Example of a Florida Pain Management Clinic Audit

• An AHCA letter comes in the mail….it is requesting 35 records...(the time frame is short--usually they need to be produced within 21 days or 30 days).
• AHCA may even provide an Excel compliance spreadsheet/checklist regarding provider credentials to be filled out, etc.
• You need to immediately conduct an internal audit of the practice (with your own personnel or outsource it to a legal expert) and these 35 records (need a written checklist for each) before you ever consider sending them in to AHCA.
• But how?
Organization’s Internal Audit and Compliance Actions

• Need to go to the “Truth Sources”—law, guidance, etc.—and create/obtain a checklist to audit the records.

• Conduct an audit of the records (and the treating provider’s credentials as well) using your own “truth source” informed checklist.
  – You can conduct this audit internally, or use an outside expert (a fresh set of eyes). It is important to identify key risk areas based on the specialty.

• This internal audit will let you know where your practice stands.
  – Based on the internal audit results, the organization will have to decide if it wants to represent itself with the Agency, or obtain qualified representation.

• No matter what, with records your organization sends in to the Agency, be sure you keep exact separate copies of anything sent in, and maintain a copy of all correspondence you have with the Agency.

• For example: In terms of Pain Management—“Medical Necessity” is a key area to focus on. Physical exam, documentation, etc.
Depending on the type of practice, there are some key audit areas

- Another Example: Behavior Analysis Services
- In terms of Behavior Analysis practices—100% currency in provider credentials is a key area to focus on. Check the official website for current Board-Certified Behavior Analysts (BCBAs) and Registered Behavior Technicians (RBTs)
- If anything is out of compliance (credentials, records, or otherwise) it is possible for the reimbursement paid for those cases (by AHCA, CMS, etc.) to be recouped by the payer...
- Then, it is likely that statistical extrapolation will be used by the Agency to make legal conclusions regarding documentation on all care provided (not just the 35 records) and hence, reimbursement regarding all care provided...
- Again, then it is up to your organization to determine if you want to deal with the Agency alone, or hire a law firm in order to help keep what you have already earned.
In Summary

• It is imperative that healthcare organizations create and maintain sufficient compliance programs.

• Professional coders are a key part of compliance programs that involve high risk areas such as billing, coding, HCFA 1500s, etc.

• Ensure that you go to the “truth sources,” and if you do not know something, do not be afraid to ask.

• Compliance programs are some good medicine to cure a lot of a healthcare organization’s potential legal ills.

• Identify what Compliance Rx you need—and then take it!
Bottom Line:
You are now on “Notice” regarding the need for a sufficient Healthcare Compliance Program

Again, it’s not a question of “IF” your organization is going to be audited, but more a matter of “WHEN.”
“An ounce of compliance program prevention is worth more than a pound of legal cure”

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