Healthcare Fraud Enforcement and Compliance Strategies

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Today’s presenters and some notes...

Welcome. With the high number of attendees, please note all lines have been muted for the event. Q&A can be posted at the right of your screen, but any questions (time permitting) will be addressed at the end of the event. If using Q&A – please send to both the host and the presenter. You can send direct questions (including request for copy of slides) to seminars@leclairryan.com with Healthcare Fraud in the subject for reply after the event.
Overview

- Healthcare Fraud Enforcement Trends
- Criminal Tools and Focus
- Civil Fraud
- Civil Exclusion Authority
- Compliance Strategies
The Numbers Tell the Story

- For FY 2011, the Justice Department recovered in civil and criminal healthcare fraud cases over $5.6 billion.
- Approximately $2.8 billion were the result of whistleblower complaints, an increase of $500 million over FY 2010.
- Congress has increased funding by nearly $1 billion to combat health care fraud and abuse enforcement.
- For each dollar spent on enforcement the government recovers or saves one-and-a-half times that amount.
Who Are Typical Target Companies?

- Pharmaceutical manufacturers
- Hospitals
- Medical device manufacturers
- Nursing homes
- Doctors
- Ambulance companies
- Manufacturers of medical tests
- Laboratory chains
Typical False Claims Act Violations

- Billing for services not rendered or goods not supplied
- Billing for “upcoded” services
- Billing for medically unnecessary services/goods
- Utilizing illegal sales and marketing schemes
- Kickbacks
- Falsifying cost reports
- Research grant fraud
Unprecedented Enforcement Collaboration

Health Care Fraud Prevention and Enforcement Action Teams (“HEATs”)

- Justice Department
  - Main Justice
  - US Attorneys Offices
  - Federal Bureau of investigation

- Health and Human Services
  - Inspector General
  - Medicare Fraud Strike Force
Health Care Fraud = Organized Crime

- HEATs resemble Organized Crime Task Forces of the past
- Search warrants, Ambush interviews, Undercover officers, Informants, Videotape and audio recordings, Asset seizures and forfeitures
- Prosecutors are successfully detaining defendants pending trial without bond or with high bonds
- Four national takedowns with arrests of over 100 individuals, including doctors, nurses, and other healthcare executives and employees
Casting a Wide Net

- Prosecutions include all participants in scheme
  - Patient recruiters who obtain Medicare numbers from beneficiaries;
  - Physicians, nurses and other licensed health care professionals who use fraudulent provider numbers to bill for unnecessary or never-provided services;
  - Owners of the companies who allegedly pay fraud facilitators from the gains of the scheme.
In January 2011, the DOJ and HHS disclosed there were 1,341 pending *qui tam* cases awaiting an intervention decision by the government:

- 885 (or 66%) of cases allege health care fraud, of which 867 (or 98%) involve Medicare or Medicaid.
Hospitals Are Prime Targets

- Seven hospitals paid $6.3 million for false claims to Medicare for kyphoplasty procedures (treatment for spinal fractures).
- The Detroit Medical Center paid $30 million for improper relationships with physicians involving reduced leasing fees, free advertising and tickets to events and seminars.
- Catholic Healthcare System paid $9.1 million for false Medicare claims for overpayments, inflated costs for home health care agencies and ineligible kidney treatment services.
Hospitals Are Prime Targets (cont.)

- Dartmouth Hitchcock Medical Center in New Hampshire paid $2.2 million for improper billing for services performed by resident physicians without required supervision.
- Columbia University Medical Center in New York City paid nearly $1 million for improper billing by doctor which hospital failed to stop after discovering potential compliance issues.
False Claims Act

- The FCA is DOJ’s principal weapon and is used in parallel with criminal investigation under Food Drug and Cosmetics Act and Anti-Kickback
- United States (or private relaters) can recover treble damages and per claim penalties ($5,500 to $11,000).
- Criminal penalties for false claims 18 U.S.C. § 287 – 5 Years Imprisonment
- FCA enforced with the assistance of private plaintiffs (whistleblowers) referred to as qui tam relaters.
- Defendants can be liable for attorneys’ fees and relaters costs.
False Claims Act Liability

- Plaintiff must show that:
  - the defendant submitted or caused the submission of a claim to the federal government;
  - the claim was false or fraudulent, or the defendant made or used false or fraudulent records or statements to obtain the claim's payment or approval; and
  - the defendant either had actual knowledge of the claim's falsity or acted in reckless disregard of the claim's validity.
False Claims Act Amendments

- **Anti-Kickback Liability.**
  - Confirms AKS violations are false claims and give rise to FCA liability (in addition to AKS penalties).
  - Claims submitted in violation of the AKS automatically constitute false claims for purposes of the FCA.
  - New language of the AKS provides that “a person need not have actual knowledge … or specific intent to commit a violation” of the AKS.

- **Reverse False Claims** – Expands liability to "knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the Government;"

- **Expansion of “Claim”** – Expanded "claim" to include “money or property spent or used on the Government's behalf or to advance a Government program or interest" and where the government provides or reimburses any portion of the requested funds;

- **Expansion of Liability for Possession of Overpayments** -- Overpayments under Medicare and Medicaid must be reported and returned within 60 days of discovery, or the date a corresponding hospital report is due. Failure to timely report and return an overpayment exposes a provider to liability under the FCA.
FCA Procedures

- **Statute of Limitations**: Action may not be brought more than 6 years from date of alleged violation, or more than 3 years after date when material facts reasonably should have been known by government, but in no event more than 10 years after alleged violation.

- **Venue**: Proper where any defendant is found, resides, does business, or in which any proscribed act occurred.
Anti-Kickback Liability

- The AKS prohibits anyone from knowingly or willfully paying or offering to pay remuneration, directly or indirectly, to another.
  - To induce that person to refer patients, or to arrange for or recommend the purchase of any facility, item or service that may be paid for by a federal health care program.

- “To induce” means “the intent to gain influence over the reason or judgment of a person making referral decisions,”
  - One purpose of the payment in question was to induce referrals, irrespective of the existence of other legitimate purposes.

- Imprisonment up to 5 years, and $25k for each violation; automatic exclusion from Medicare, Medicaid, and other federally-funded federal healthcare programs. Civil penalties of $50k for each violation plus three times the remuneration offered, paid, solicited or received.
Use of Non-Health Care Criminal Fraud Statutes

- Mail and Wire Fraud are easier to prove and require a lower showing of criminal intent.
- Health care fraud statute, 18 U.S.C. § 1347, requires the government to prove that the defendant “knowingly and willfully” executed a scheme or artifice to defraud any health care benefit program of false information.
- Government needs to show that defendant sent wire (or mailed document) to further scheme or artifice to defraud and sent a message for purposes of executing the scheme.
- Lower standard of proof gives the government greater leverage over defendants.
Civil Exclusion Authority: A New Weapon

- HHS-OIG has added to the enforcement muscle by using its exclusion authority against health care participants.
- Felony criminal convictions related to health care programs result in a mandatory exclusion for a minimum of five years under 42 U.S.C. § 1320a-7(a).
- Almost half of the exclusions are based on criminal convictions for fraud crimes related to Medicare, Medicaid, or other health care programs.
- HHS-OIG has justified requesting longer exclusion periods, and in some cases has sought life long exclusions.
Physician Payments Sunshine Act

- January 2013 new rules kick in requiring to record and disclose any payments or benefits to physicians.

- Congress believes drug and device companies are flouting anti-kickback laws by enriching physicians and creating detrimental conflicts of interest.

- Prosecutors will comb this data for investigative leads and initiate AKB investigations.
Identification of Potential Fraud

- DOJ, HHS and related agencies use a number of strategies to identify, investigate and prosecute health care fraud.
- The Center for Medicare and Medicaid (CMS) has initiated new procedures to identify unusual billing patterns which suggest potential fraud.
- CMS’ new program is based on predictive modeling technology and works like existing fraud programs used by financial institutions for credit cards and debit cards.
- The CMS program uses a scoring system to identify suspect providers and to rate those providers based on a series of metrics designed to identify billing abnormalities.
Compliance Strategies: Protection Against Liability
The Need for Proactive Compliance

- An effective compliance program can actually reduce the number and extent of possible FCA violations.
- Compliance program helps establish that any violation was consequence of negligence or the conduct of a rogue employee,
- An effective program can help to convince the government not to intervene
- The government’s decision to intervene or not to intervene can be decisive.
  - Over 95 percent of qui tam recoveries occur in cases in which the government decides to intervene.
  - Only a slim number of cases are successful when the government chooses not to intervene.
Compliance Program Strategies

- There is a rich history of compliance in the health care industry.
- Proactive commitment to compliance and improving compliance
- Create a culture of compliance to define compliance standards and procedures
- Health care organizations need to dedicate adequate resources to the compliance function
- Compliance program must have a procedure for ongoing risk assessments – this is the lifeblood and intelligence foundation of every compliance program.
Compliance Program Elements

- A Written Code of Conduct and Compliance Policy
- Tone at the Top Message from Senior Management and Commitment to Code of Conduct and Compliance Policies
The Chief Compliance Officer

- Authority and resources
- Clear and direct line of communication to Compliance Committee or Audit Committee
- CCO must be a Senior Manager equivalent to other C-Level offices
- CCO must be proactive and coordinate closely with internal auditors and general counsel
Training and Communication

- Training programs conducted on regular basis

- Training program must stress proper coding of services and the need to have chart documentation to support every claim.

- Continuing communications from senior management to reinforce commitment to compliance

- Annual employee certifications to reinforce compliance program

- Compliance and ethics must be part of employee evaluation
Internal Reporting Systems

- The most important check on fraud is encouraging employees to identify potential problems, to report them to the compliance officer and to address these complaints.
- Human resources should also be on the alert for warning signs that there may be potentially disgruntled employees or students.
- Systems should include anonymous reporting programs (Internet or hotline).
- Complaint system should be monitored and tracked
Whistleblowers: The Dangers

- Triage program for assessing complaints and launching internal investigations when appropriate.
- A team of investigators should be on call to respond to matters as they arise.
- Human Resources needs to ensure that there is no retaliation against a reporting employee, which can itself give rise to a separate legal action against the hospital.
- The reporting employee should be given feedback so the employee knows that his or her concerns and reports are being taken seriously. If ignored, the employee may become a whistleblower and file an FCA lawsuit.
- Reporting of identified issues to senior management and Board
Enforcement and Discipline for Violations

- Discipline procedures need to be established so that uniform policies and treatment of employees for violations
- Matters need to be handled quickly, efficiently and in a consistent manner.
Monitoring and Auditing Program

- Revision and improvement of compliance program through regular risk assessments
- Measuring program performance
- Monitoring and Auditing procedures and programs which are developed from a risk assessment and includes reviewing previous audits, monitors and other pertinent internal and external information and sharing information and results across the organization.
Auditing

- The most significant risk centers on billing and coding of services for reimbursement from Medicare.
- No one can review every bill or watch over every employee, but basic compliance principles can be adopted to minimize risks.
- Documentation and internal controls are key to ensure compliance and identify potential problems.
- Given the complexity of the billing and coding system, every doctor or hospital will make mistakes.
- It is important to build in practices and procedures to reduce billing errors and fix the problem once it is discovered. Corrective efforts need to be documented and measure for frequency.
- Auditing for potential fraud must be regularly conducted. A sampling of claims and charts should be identified, reviewed and, if necessary submitted for outside review.
QUESTIONS?
THANK YOU!

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