The Health Care Regulatory Environment: Fraud and Abuse

June 29, 2012

Jim Taylor

MILLIGAN LAWLESS, P.C.
Overview

• The environment
• Key “fraud and abuse” laws
• Dangerous misconceptions
• Risk management
The Environment: The Good Old Days

Twenty-five years ago there were few if any regulations governing physician practices; an attorney who represented physicians was a: Tax lawyer, Malpractice lawyer or Divorce Lawyer.
The Regulatory Environment Today


Brian R. Riveland, M.D., *Alphabet Soup*, Maricopa County Medical Society Roundup.
Economics: Health Care Reform Will be Costly

- $122.6 Billion a year?
- $136 Billion?
- $150 Billion?
- $298 Billion?
- $1-$2 Trillion over ten years?

Uwe Reinhardt
Economix, June 12, 2009.
“Fraud and Abuse” Costs Billions

Eric Holder says:

• $60 billion annually
• Half of the economy of Kansas
• More than the net worth of the eight largest foundations.
• 33 times the gross of the biggest box office movie of all time.

- www.mainjustice.com (Jan. 28, 2010)
The Economic Environment

- Health care reform will be costly.
- Fraud and abuse costs billions:
  - CMS estimates that almost 8% of the fee for service payments in 2009 ($24.1 billion) did not meet payment requirements.
- Estimates of ROI from enforcement activities range from
  - 6.8:1 (Sec. Sibelius)
  - 15:1 (Taxpayers against fraud)
Enforcement is Big Business…

December 13, 2011

• The Obama Administration announced recovery of over $5.6 billion in fraudulent payments in fiscal year 2011

• A 167 percent increase from 2008.
and Business is Booming.

“Data Analysis Finds Health Care Fraud Investigations up 85% in 2011.”

• Up 157% from five years ago and 822% from twenty years ago.
and Booming…

- $1.63 billion in judgments and settlements in 2009.
- The Medicare Trust Fund received transfers of approximately $2.51 billion during this period, in addition to over $441 million in Federal Medicaid money.
- The HCFAC account has returned over $15.6 billion to the Medicare Trust Fund since the inception of the Program in 1997.

DHS/DOJ HCFA Control Program, 2009 Annual Report
and Booming….

- 1,014 new criminal health care fraud investigations involving 1,786 potential defendants.
- 1,621 health care fraud criminal investigations pending, involving 2,706 potential defendants
- 481 criminal cases involving 803 defendants
- 583 defendants convicted of health care fraud-related crimes
- 886 new civil health care fraud investigations and 1,155 civil health care fraud matters pending

DHS/DOJ HCFA Control Program, 2009 Annual Report (These figures don’t include OIG, state agencies, etc.)
Additional Investment

• Patient Protection and Affordable Care Act
  – $10 million in additional funding for the Health Care Fraud and Abuse Control Account, 2011 – 2020.
  – $250 million per year in additional funding for the Medicare Integrity Program, 2011 – 2016.
  – $75 million per year in additional funding for the Medicaid Integrity Program increase.

• Where will they focus their efforts?
Recovery Audit Contractors: No-Cost Enforcement

• RAC contracts awarded in four regions. Arizona is in Region D, and the RAC is Health Data Insights, [https://racinfo.healthdatainsights.com/](https://racinfo.healthdatainsights.com/).

• Like personal injury attorneys, RACs get paid on a contingency basis.

• RAC reviews include:
  – Review of medical records for medical necessity, compliance with Medicare payment rules, etc.
  – Automated claims review for, e.g., duplicate charges.
  – Review of areas of concern identified by CMS or Office of Inspector General
The Willie Sutton Rule

• Why is so much money being spent on health care enforcement?

2. ROI
Future Enforcement Trends

Given:

• The cost of health care,
• The federal budget,
• The real and imagined cost of F&A,
• The ROI on enforcement activities, and
• The lack of any pushback from organized medicine, enforcement efforts will continue to expand.
The Key Fraud and Abuse Laws

- The Anti-Kickback Act
- The Stark Amendments
- The False Claims Act
- The Civil Monetary Penalties Statute
The Anti-Kickback Act

Enacted in 1972, the Act prohibits:

- “knowingly and willfully”
- offering, soliciting, paying or receiving “remuneration”
- as an inducement
- for referring, purchasing, leasing, ordering any item or service paid for by a federal health care program
Anti-Kickback Act

A very broad prohibition.

• “Remuneration” means anything of value.
• Judicial Interpretation:

The Act is violated if “one purpose” of the remuneration was to induce further referrals.
Anti-Kickback Act

Possible Kickbacks:

• A hospital leases space on its campus to a physician group; the lease rate is later found to be below fair market value?

• A medical device company pays a physician $500 per hour for poorly defined consulting services?

• Dr. A. gives basketball tickets to referring Dr. B?
Anti-Kickback Act

Penalties:

• $25,000 in fines, imprisonment or both
• Civil money penalties
  – Treble damages
  – $50,000 per violation
• Exclusion from government programs
• False Claims Act liability
Joint Ventures

• 1989 OIG Special Fraud Alert re Joint Ventures
  – Focuses on physician’s investments

• 2003 OIG Special Advisory Bulletin re Contractual Joint Ventures
  – Focuses on physician’s contractual arrangements

• Numerous Advisory Opinions
Joint Ventures

- The OIG defines a “joint venture” as “any common enterprise with mutual economic benefit.”

- “A joint venture may take a variety of forms: it may be a contractual arrangement between two or more parties to cooperate in providing services....”
Investment Joint Ventures

• The Fraud Alert identifies “examples of indicators of potentially unlawful activities:”
  – Investors are chosen because they are in a position to make referrals
  – Physicians who are expected to make a large number of referrals may be offered a greater investment opportunity in the joint venture than those anticipated to make fewer referrals
  – Physician investors may be actively encouraged to make referrals to the joint venture, and may be encouraged to divest their ownership interest if they fail to sustain an “acceptable” level of referrals
Investment Joint Ventures

• Fraud Alert examples continued:
  – The joint venture tracks its sources of referrals, and distributes this information to investors
  – Investors may be required to divest their ownership interest if they cease to practice in the service area, for example, if they move, become disabled or retire
  – Investment interests may be non-transferable
Investment Joint Ventures

• Fraud Alert examples continued:
  – The amount of capital invested by the physician may be disproportionately small and the returns on investment may be disproportionately large when compared to a typical investment in a new business enterprise
  – Investors may be paid extraordinary returns on the investment in comparison to the risk involved, often over 50% to 100% per year
Contractual Joint Ventures

• The Bulletin “focuses on questionable contractual arrangements where a health care provider in one line of business (… “Owner”) expands into a related line of business by contracting with an existing provider of a related item or service (… “Manager/Supplier”) to provide the new item or service to the Owner’s existing patient population, including federal health care program patients.”
Contractual Joint Ventures

• “[E]ven if the various contracts [between the Owner and the Manager/Supplier] could fit in one or more safe harbors, they would only protect the remuneration flowing from the Owner to the Manager/Supplier for actual services rendered.”

• “By agreeing effectively to provide services it could otherwise provide in its own right for less than the available reimbursement, the Manager/Supplier is providing the Owner with the opportunity to generate a fee and profit. The opportunity to generate a fee is itself remuneration that may implicate the anti-kickback statute.”
Joint Ventures

• Examples of Joint Ventures:
  – Physician-owned distributors
  – Investments in “under arrangement” providers
  – Any subcontracted line of business to which physicians refer their patients
    • DME
    • Clinical lab
    • Diagnostic tests
    • Prescription drugs
    • Infusion services
    • Anesthesia services
Anesthesia Company Models

- Many Varieties
- Some OK
- Some Not So Much
Anesthesia Company Models

• “Management Services” Model

Anesthesia Group pays the ASC for:
  • Pre-operative nursing assessments
  • Space for physicians’ personal effects
  • Assistance with billing documentation

Per Patient Fee

Governmental Payors - Excluded
Anesthesia Company Models

- “Separately Owned Anesthesia Company”
  - Owned by owners of ASC
  - Exclusive provider of anesthesia services to ASC
  - Contract with anesthesiologists or anesthesiology group to provide the anesthesia-related services
March 19, 2009

Inspector General Daniel R. Levinson
Office of Inspector General
United States Department of Health and Human Services
Room 5541 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Levinson,

The American Society of Anesthesiologists (ASA), representing over 43,000 members, has received increasingly frequent concerns from its members regarding an economic model that potentially violates the Federal anti-kickback provisions of the Social Security Act (the Act) (section 1128B), and/or the prohibition of self-referrals of the Act (section 1877). The ASA respectfully requests the Office of Inspector General to issue a Special Advisory Bulletin on the economic model ("company model") described below.
Contracting With Your Anesthesia Group
by Bruce Armon, Franklin Dexter, MD, PhD
October 2009

When negotiating a contract with your anesthesia group, you'll spend considerable time discussing such usual sticking points as compensation, length of contract and how to handle unused OR time. But other, less-apparent issues are as important, chief among them: Does your agreement comply with the federal anti-kickback statute and its regulations?

ASCs must be particularly mindful of their relationships with anesthesia providers regarding staffing, billing and referral relationships. Similarly, anesthesia groups can level the playing field against ASC owners during contract negotiations and protect against one-sided arrangements if they understand the governing laws and regulations. This article examines 3 types of joint-venture arrangements between ASCs and anesthesia groups and considers the level of legal risk associated with each model.
“When asked why he robbed banks, Willie Sutton responded, “Because that’s where the money is.” Owners of ambulatory surgery centers (ASCs), who often are surgeons, are seeking a share of anesthesia fees for the same reason. But instead of a gun, many are turning to a new model of money extraction: the company model.”

[We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.]

Issued: May 25, 2012

Posted: June 1, 2012

[Name and address redacted]

Re: OIG Advisory Opinion No. 12-06

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding two proposals by an anesthesia services provider to enter into contracts with physician-owned professional corporations or limited liability companies to provide anesthesia services (“Proposed Arrangement A” and “Proposed Arrangement B,” respectively, and, together, the “Proposed Arrangements”). Specifically, you have inquired whether the Proposed Arrangements would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the “Act”), or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.
Anesthesia Company Models

• Does excluding Federal Program patients remove application of the Anti-Kickback Act?
• No.

Such arrangements may disguise “remuneration for Federal health care program business through the payment of amounts purportedly related to non-Federal health care program business.”
Anesthesia Company Models

- Management Services Model

The ASC “would continue their current practice of billing for and collecting facility fees with respect to both Federal and non-Federal health care program patients, and also would begin charging the [Anesthesia Group] for services that those facility fees are intended to cover for non-Federal health care program patients. In short, the Centers would be paid twice for the same services …”
Anesthesia Company Models

• Separate Anesthesia Company Model

“The OIG has long-standing concerns about arrangements, such as joint ventures, between those in a position to refer business, such as the Centers’ physician-owners here, and those furnishing items or services for which Medicare or Medicaid pays, especially when all or most of the business of the joint venture is derived from one or more of the joint venturers.”
Anesthesia Company Models

- Separate Anesthesia Company Model

“[A] health care provider in one line of business [the Owner] expands into a related health care business by contracting with an existing provider of a related item or service [the Supplier] to provide the new item or service to the Owner’s existing patient population, including [F]ederal health care program patients.”
Another Hot Topic . . .

- Out-Of-Network Waiver of Co-Pay and Deductibles
  - Insurance companies are fighting back
  - States are responding
Out-Of-Network Waiver of Co-Pay and Deductibles

• Insurance companies are fighting back
• States are responding
• State Insurance Fraud Statutes
• Federal Attacks:
  – Conspiracy
  – Mail Fraud
  – Health Care Fraud Statute (HIPAA 1996)
Out-Of-Network Waiver of Co-Pay and Deductibles

• Arizona Department of Insurance
  – Taken the position that it is insurance fraud
  – Misrepresentation of the charge for the service
South Bay surgery clinics overbilled, insurance giant claims

By Lisa M. Krieger and Beth Mole
San Jose Mercury
Posted: 06/02/2012 08:36:13 PM PDT
Updated: 06/18/2012 04:30:48 PM PDT

Thomas Elardo is a successful podiatrist -- one of Silicon Valley's best and busiest -- but he knew how hard it is these days to make good money in medicine.

So he knew "something wasn't right" when another doctor one night at a restaurant showed him a $980,000 "bonus check" and invited him to become part of a surgery center.

Aetna Insurance reached the same conclusion: In a $20 million lawsuit, it claims the Santa Clara County company behind that check is making millions of dollars and enriching doctors by sidestepping state laws meant to protect patients and control costs. The suit says Saratoga-based Bay Area Surgical Management has recruited dozens of local doctors to invest in its outpatient facilities and

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Jun 21:
Owners of San Jose medical office building withdraw permit application for residential care facility

Jun 19:
San Jose Planning Commission to consider permit on post-surgical care facility
South Bay surgery facilities sued for $39 million by second insurer
South Bay surgery facilities sued for $39 million by second insurer

By Lisa M. Krieger

lkrieger@mercurynews.com
Posted: 06/19/2012 08:54:53 AM PDT
Updated: 06/19/2012 08:55:06 AM PDT

A second insurance giant has sued Saratoga-based Bay Area Surgical Management and its five facilities, claiming that the company submitted inflated and fraudulent bills.

The suit, filed Monday by United Healthcare Services, echoes assertions in a $20 million Aetna Insurance suit filed early this year that the company is making millions of dollars and enriching local doctors by sidestepping state and federal laws meant to protect patients and control costs.

Bay Area Surgical Management strongly denies the allegations, saying that they are inaccurate -- and represent part of a larger strategy by the two insurers to force the company to sign a contract that sets very low reimbursement rates for patient care.

"It's a strong arm tactic," said Bobby Sarnevesht of BASM. "They think if they come at us, all at once, we'll be bullied into signing an unfavorable contract."

The company, which manages outpatient surgical centers, says it gets paid just a fraction of the sums that insurers pay to surgery centers affiliated with hospitals like Stanford and El Camino.
Dangerous Misconceptions
Dangerous Misconceptions

• “The odds are it will never happen to me.”
• “They are only going after the big guys.”
• “They are only going after ‘real criminals.’”
• “It’s not happening here.”
• “They aren’t going after my specialty.”
• “It’s not my problem.”
• “I’ll fight them if they come after me.”
“The odds are it won’t happen to me.”

- Odds of being killed in a transportation accident: 77 to 1
- Odds of being killed in any sort of non-transportation accident: 69 to 1
- Odds of being struck by lightning: 576,000 to 1
- Odds of being killed by lightning: 2,320,000 to 1
- Odds of being murdered: 18,000 to 1
- Odds of getting away with murder: 2 to 1
- Odds of an Illinois governor being charged in a criminal case: 1 to 1
- Odds of being the victim of serious crime in your lifetime: 20 to 1
- Odds of dating a supermodel: 88,000 to 1
- Odds of being considered possessed by Satan: 7,000 to 1
- Odds of an F&A audit, investigation: ?
What are the odds of an investigation?

- The enforcement environment;
- RAC audits;
- Carrier/WIC audits;
- Qui tam lawsuits;
- Reports or complaints from
  - Patients
  - Ex-employees, shareholders, etc.
  - Spouses in divorce proceedings;
  - Med mal plaintiffs;
“The odds are....”

- HHS Website for patients to report:
  - HHSTips@oig.hhs.gov
  - Call: 1-800-HHS-TIPS
  - 1-800-447-8477)

- Qui tam lawyers
  - A Google search for “qui tam healthcare lawyers” yields 526,000 hits.
Figure in Blagojevich scandal charged with bribing doctors

Staff report
2:32 p.m. CDT, June 20, 2012

Raghuveer Nayak, a former fundraiser for U.S. Jesse Jackson Jr. and Rod Blagojevich and a key figure in the U.S. Senate seat scandal, was arrested at his Oak Brook home this morning and charged with bribing doctors to send patients to his surgery centers.

Nayak was charged with mail fraud, interstate travel in aid of racketeering and filing false income tax returns in a 19-count indictment, according to the U.S. attorney's office. Prosecutors are seeking $1.8 million in "alleged fraud proceeds," including forfeiture of Nayak’s Oak Brook home, his Rogers Park One Day Surgery Center and his Lakeshore Surgery Center.
“They are only going after the big guys....”

• McAllen Urologist and Wife Indicted for Health Care Fraud (2011) -
• Urologist Please Guilty to Fraud Over Dosages (2003) - Maine Urologist Guilty of Fraud (2004) -
• Five Urologists Plead Guilty to Healthcare Fraud (2008)
“They are only going after the big guys….”

- Scottsdale Doctor Pleads Guilty to Health Care Fraud (2010)
- Michigan Physician Sentenced to 72 Months in Prison for Medicare Fraud Scheme (2010)
- Physician Sentenced to One Year in Prison for Health Care Fraud (2010)
- Pennsylvania Physician Sentenced to Prison for Healthcare Fraud (2010)
- Five Physicians, Six Others Charged in Sacramento-Based Medicare Fraud Scheme (2010)
- Texas Physician Charged With Healthcare Fraud (2010)
“They are only going after the big guys….”

- Michigan Physician Pleads Guilty to Fraud (2010)
- Florida Physician Charged as Part of Healthcare Fraud Sting (2010)
- New Jersey Neurologist Indicted for Healthcare Fraud (2010)
- California Oncologist Sentenced to Prison for Cancer Medications That Were Never Provided (2011)
- Maryland Cardiologist Convicted for Inserting Unnecessary Cardiac Stents (2011)
- Washington Oncologist and Wife Indicted for Twenty Counts of Healthcare Fraud (2011)
• Oncologist Charged with Health Care Fraud (2009) -
• Texas Oncologist Charged with Healthcare Fraud (2010)
• Radiation Oncologist and Healthcare Facility Pay $12 to Settle False Claims (2010) -
• Las Vegas Physician to Pay $5.7 mil to Resolve False Claims Act Allegations Related to Radiation Oncology Services (2011) -
“They are only going after the ‘real criminals’…..”

- Cardiologist pays $1.3MM for "services not provided, and in other instances, claims were submitted without proper documentation" (2009)
- Three cardiologists in Arizona pay $355,000 to settle alleged Stark violations (2009)
- Physician compensation sparks $4.5 million settlement in Iowa (2009)
- AHH/AHI settlement relating to billing for carotid stents (2009)
- Christ Hospital settlement (2010)
- Rush pays $1.5MM Stark settlement based on defective leases to physicians (2010)
Brooklyn, N.Y., Medicare Fraud Strike Force Charges 12 Individuals for Participating in Health Care Fraud Schemes Totaling More Than $95 Million

WASHINGTON – Twelve individuals, including three medical doctors, a doctor of osteopathy and a chiropractor, were charged today in the Eastern District of New York for their roles in separate health care fraud schemes that resulted in the submission of more than $95 million in false claims to the Medicare program, announced the Department of Justice, the FBI and the Department of Health and Human Services (HHS).

The defendants are charged with a variety of health care fraud-related and money laundering offenses in two indictments and a superseding indictment filed in federal court in Brooklyn, N.Y. Eleven defendants were arrested or surrendered to authorities today. The last defendant is expected to surrender at a later time.

"Today 12 individuals – including three medical doctors and other licensed health professionals – were charged with participating in sophisticated Medicare fraud and money laundering schemes throughout Brooklyn and Queens," said Assistant Attorney General Lanny A. Breuer of the Justice Department’s Criminal Division. "According to court documents, these defendants sought to profit by stealing millions of taxpayer dollars from the Medicare program and laundering the proceeds of this illegal activity. The Medicare Fraud Strike Force, which operates in nine cities across the country, will continue to aggressively pursue those intent on cheating American taxpayers and stealing from the Medicare program."

The defendants all pleaded not guilty at today’s hearing and were ordered to return to court for a trial setting on December 6, 2011.
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“It’s not happening here….”

- United States Reaches $400,000 Settlement with Sierra Vista, Ariz., Doctor (2009)
- U.S. Reaches $675,000 Settlement With Arizona Heart Hospital Over Medicare (2009)
- Tucson cardiologists settle Stark allegations (2009)
- Parker Physician to Pay Federal Government $430,000 for False Medicare Billings (2010)
- Scottsdale Doctor Pleads Guilty To Health Care Fraud (2010)
- Terry Goddard Announces Indictment of Doctor in Prescription Drug Case (2010)
- Arizona Physician to Pay $395K to Settle False Claims Allegations (2010)
“It’s not my problem…."

• FCA liability risk exists for all who “present or cause to be presented” a false claim.
  – The physician who performed the service?
  – Others with knowledge?
  – The Practice?
  – The Practice’s Directors and Officers?

• The “corporate shield” isn’t a shield.

• No physician ever “wins” a fraud and abuse case.
  – Expense (the cost of defending an investigation successfully can run several hundred thousand dollars)
  – Anxiety
  – Collateral consequences
“I’ll fight them if they come after me.”

- FCA penalties of up to $11K per claim.

*United States v Lorenzo*

- A dentist who submitted 3,683 false claims
- And received $130,719.10 in payments
- Was subject to a civil judgment of
- $18,415,000 in penalties.
“I’ll fight them if they come after me.”

• FCA penalties of up to $11K per claim. *United States vs Dr. Krizek.*
  – In a suit against a psychiatrist accused of overbilling, totaling $245,392 during a six year period,
  – The government sought amounts paid and the maximum penalty amount, which yielded a claim for $80,750,000.
No One Wins a F&A Case

• Anxiety about civil damages and criminal exposure;
• Legal and expert fees;
• Concerns about collateral damage:
  – Exclusion from participation
  – Board action
  – Contract termination
What are the odds?

“Bummer of a birthmark, Hal.”
Risk Management
Risk Management

• Facility behaviors
  – Contract reviews for compliance
  – Internal evaluations and self-reporting
  – Compliance program

• Provider behaviors
  – Documentation
  – Documentation
  – Documentation
Internal Evaluations and Self-Reporting

• Internal evaluations help identify and correct risky behaviors
  – Identify and correct over-charges and under-charges
  – Reduce survey and medical malpractice risks

• Self-reporting will help
  – Reduce civil and criminal sanctions
  – Undermine potential claims of intentional misbehavior

• Self-reporting will not (so far) increase audit risks, etc.
Consequences of a Failure to Report Overpayments

42 USC Section 1320a-7b(a)(3)

• A person who has knowledge of any event affecting his initial or continued right to payment and who “fails to disclose such event...with an intent fraudulently to secure such ... payment when no such ...payment is authorized ... shall ... be guilty of a felony....”

• Punishable by five years and $25,000.00 (per event?)
The Obligation to Self-Report/Repay

- 42 USC Section 1395nn(g)(2) (obligation to “timely refund” any amount received in violation of Stark)
- 42 CFR 411.353(d) (obligation to timely refund)
- 42 USC 1395nn(g)(3) (CMP for failure to refund)
- 42 CFR 1003.102(b)(9) (Penalty or assessment for failure to refund)
The Obligation to Self-Report/Repay

- It is a violation of the FCA to knowingly retain government overpayments.
- The FCA requires a provider to report and return an overpayment within 60 days after it “identified” the overpayment. Failure to comply with these requirements gives rise to liability under the FCA.
Compliance Plans

• Widely used in the defense industry in the 1980s; promoted in health care in the 1990s.
• Under the Federal Sentencing Guidelines, an effective Plan can reduce criminal penalties for corporations.
• An effective plan also decreases the risks and potential consequences of violations.
Compliance Plan Elements (from the FSGs)

1. Compliance standards & procedures
2. Assignment of oversight responsibilities
3. Employee training
4. Monitoring and auditing
5. Enforcement and discipline
6. Prevention and response to violations
Compliance Plans

- Today, they are a good idea. Tomorrow, they will be required:
- PPACA Section 6401 obligates the Secretary of DHHS to develop regulations requiring compliance programs for “certain providers” as a condition of participation in Medicare, Medicaid and CHIP.
Physician Documentation

• Potential fraud and abuse liability

• Medical malpractice risk

• Survey risk
Another Myth: “Medical care matters; documentation doesn’t.”

“No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

Social Security Act §1833(e)
“Unartful” documentation and FCA Liability

• On appeal of an adverse FCA determination and imposition of penalties and other sanctions, the provider argued that it provided appropriate services, but documented poorly. The Court was unmoved:

“We are not persuaded by this argument. Section 1320a-7a(a)(1)(A) prohibits the submission of claims which were not provided as described in the Medicare claim submitted. The standard of care imposed by this requirement is an exacting one, and an "unartful" description of medical services in a Medicare claim is a description of services that were not provided as claimed.”

Anesthesiologists Affiliated v Sullivan
RAC Audits and Documentation-Related Problems

• According to data provided by the RACs:
  – 40% of their recoveries related to incorrect coding (documentation did not support the code?);
  – 32% involved medical necessity determinations (documentation did not support necessity?); and
  – 9% were “pure” documentation issues.

• Since documentation deficiencies are the basis for many coding and medical necessity claims, it is probably the biggest source of repayments.
Questions?