HEAT PROVIDER COMPLIANCE TRAINING

TAKE THE INITIATIVE.
Cultivate a Culture of Compliance With Health Care Laws

WELCOME

Sponsored by: OFFICE OF INSPECTOR GENERAL (OIG) AND ENFORCEMENT ACTION TEAM (HEAT)
Agenda

• Welcome
• Session 1: Cultivating a Culture of Compliance
  – Break
• Session 2: Know Where to Go When a Compliance Issue Arises
  – Break
• Session 3: Understanding the Consequences of Health Care Fraud
• Closing Remarks
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Health Care Fraud Prevention
And Enforcement Action Team (HEAT)
Cultivating a Culture of Compliance

• Navigating the Fraud and Abuse Laws
• Compliance Program Basics
• Operating an Effective Compliance Program
• Understanding Program Exclusions
Navigating the Fraud and Abuse Laws
Navigating the Fraud and Abuse Laws

A Roadmap for New Physicians

Avoiding Medicare and Medicaid Fraud and Abuse

www.oig.hhs.gov

Office of Inspector General
Navigating the Fraud and Abuse Laws

- Physician Self-Referral Law
- Anti-Kickback Statute
- False Claims Act
- Civil Monetary Penalties Law
- Exclusion Authorities
Improper Referrals can lead to:

• Overutilization
• Increased costs
• Corruption of medical decision-making
• Patient steering
• Unfair competition
Physician Self-Referral Law

Limits physician referrals when there is a financial relationship with the entity
Navigating the Fraud and Abuse Laws

Three Questions:

1. Is there a referral from a physician for a designated health service (DHS)?

2. Does the physician (or an immediate family member) have a financial relationship with the entity providing the DHS?

3. Does the financial relationship fit in an exception?
Penalties for Physician Self-Referral Violations:

- Payment denial
- Monetary penalties
- Exclusion
Navigating the Fraud and Abuse Laws

Stark Law Compliance Tips:

1. Meet a Stark Law exception.
2. Document financial relationships with referring physicians.
3. Have systems to ensure properly structured payments.
4. Watch out for “lease creep” problems.
5. Review productivity bonuses.
6. Gifts can implicate the Stark law too.
Anti-Kickback Statute

Prohibits asking for or receiving anything of value to induce or reward referrals of Federal health care program business
Navigating the Fraud and Abuse Laws

Penalties for Kickbacks

Fines

Prison Time

Program Exclusion
Anti-Kickback Statute Compliance Tips:

1. Use a safe harbor.
2. It’s a “one purpose” test.
3. FMV for actual/necessary services.
The False Claims Act

Prohibits the submission of false or fraudulent claims to the Government
Navigating the Fraud and Abuse Laws

Deliberate ignorance
Navigating the Fraud and Abuse Laws

Civil Monetary Penalties
Exclusion from Medicare and Medicaid

Mandatory exclusions

Permissive exclusions
Compliance
Program Basics
Affordable Care Act: Mandatory Compliance Plans Coming Soon

Where do things stand now?

• CMS has NOT finalized the requirements

• CMS will advance specific proposals at some point in the future
What is a compliance program?
Seven Fundamental Elements

1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Internal monitoring
6. Enforcement of standards
7. Prompt response
Where can I look for guidance?

www.oig.hhs.gov

Let’s go there now!
Fraud Prevention and Detection

• Compliance Program Guidance
• Fraud Alerts, Special Advisory Bulletins, and other Guidance
• Advisory Opinions
Practical Tips

#1 Make compliance plans a priority now

#2 Know your fraud and abuse risk areas
Practical Tips

#3 Manage your financial relationships

#4 Just because your competitor is doing something doesn’t mean you can or should.
#5  When in doubt, ask for help
Operating an Effective Compliance Program
Once a compliance program has been established, develop a process to evaluate it and measure its effectiveness.
Policies and Procedures

Policies and procedures are up-to-date and user-friendly.
Tips to Measure Effectiveness

• Develop benchmarks and goals in team with Compliance Committee, Board, and department managers

• What do you want to measure?
Train Your Staff

• Test knowledge

• Make training part of the job

• Compliance staff/officer education & networking
Open Lines of Communication

- Solicit feedback
- Maintain visibility with employees
Make an Audit Plan

- Proactively audit:
  Coding
  Contracts
  Care
Act promptly when issues arise

Take and document corrective action
Understanding Program Exclusions
The OIG has the authority to exclude individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs.
What is the effect of exclusion?

Excluded individual or entity cannot be paid, directly or indirectly, by the Federal health care programs, for any items or services they provide.
Exclusion Basics

• **Types:** Mandatory and Permissive.

• **Who:** Any individual or entity.

• **Time:** Generally defined period, but certain may be indefinite in length.
Checking for Exclusion

- Screen against the OIG’s List of Excluding Individuals/Entities.
  www.oig.hhs.gov/fraud/exclusions.asp.

- Self-disclose if you discover you have employed an excluded individual

- Maintain documentation of searches
Break
Know Where to Go When a Compliance Issue Arises

- Navigating the Government
- Overview of CMS
- Importance of Documentation
- Subpoenas, Audits, and Surveys
- Self-Disclosure
Navigating the Government

Key Players in the Healthcare Industry

- Medicare and Medicaid
- Enforcement Entities
- Regulatory Agencies
How do you know where to turn for help?

KEY: Identify the general nature of your issue.
Navigating the Government

Recommended Compliance Resources Handout
Today’s Presentation

• CMS Structure and Approach to Program Integrity

• CMS Contractors and Partners

• Resources
The Centers for Medicare & Medicaid Services

- Federal agency that has oversight of the Medicare, Medicaid, and Children’s Health Insurance Program (CHIP).
- Over $800 billion spent each year on these programs.
  - 19% of the total Federal budget
- Over 100 million beneficiaries
  - Covering 1 in 4 Americans
The Medicare Business

- Each working day, Medicare:
  - Pays over 4.4 million claims
  - To 1.5 million providers
  - Worth $1.1 billion

- Each month, Medicare
  - Receives almost 19,000 provider enrollment applications

- Each year, Medicare:
  - Pays over $430 billion
  - For more than 45 million beneficiaries
The Medicaid Business

- Each year, Medicaid, nationally:
  - Pays over 2.5 Billion claims
  - For more than 54 million beneficiaries
  - 56 State and territory-administered programs

- By 2014, Americans who earn less than 133 percent of the poverty level (approximately $29,000 for a family of four) will be eligible to enroll in Medicaid.

- 8.8 million (18%) of Medicaid beneficiaries are “dual eligibles” who also qualify for Medicare coverage.
Background of CPI and Focus

• History of the Center for Program Integrity:
  – March 23, 2010 – The Affordable Care Act was enacted.
  – April 11, 2010 – Secretary Sebelius realigns CMS into 5 Centers, creating the Center for Program Integrity.

• Focus:
  – Consolidate Medicare and Medicaid program integrity efforts.
  – Move away from the pay and chase approach toward focus on prepayment prevention efforts.
  – Focused intervention.
  – Increase public/private cooperation.
Program Integrity

- **Program Integrity** encompasses a range of activities to target the various causes of improper payments:

  - Mistake
  - Inefficiency
  - Bending the rules
  - Intentional Deception
  - Error
  - Waste
  - Abuse
  - Fraud
CMS Contractors and Partners
### Medicare Program Integrity Partners & Approaches

<table>
<thead>
<tr>
<th>MACs and Legacy Contractors</th>
<th>• Process claims, Enroll providers, screen beneficiary fraud complaints, Refer potential fraud to ZPICs</th>
</tr>
</thead>
</table>
| Zone Program Integrity Contractors | • Seven by end of 2010.  
• Investigate fraud leads and build fraud cases.  
• Work with MACs and law enforcement. |
| CMS Field Offices | • Current locations include Miami, Los Angeles, New York City; Boots on ground; Investigate fraud leads and liaison with law enforcement. |
| External Partners | • Law Enforcement, Accreditation Bodies, State Medicaid and Survey Agencies, Others |
| Data Analysis | • Used for pre and post payments to identify possible fraud schemes and review of claims from high risk providers and suppliers |
Medicare Program Integrity Partners & Approaches

RAC’s
- Detects and corrects past improper payments
- Requests additional documentation, when necessary

QIC’s
- “Qualified independent contractor”
- Provides independent review of appealed claims

NSC
- National Supplier Clearinghouse
- Registers suppliers for participation in Medicare

COB
- Coordination of benefits contractor
- Determines whether Medicare is primary or secondary and assures payments comply
Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

A
NHIC

B
National Government Services

C
CIGNA Government Services

D
Noridian Administrative Services
– Program Integrity for Medicare Parts C and D

– National Jurisdiction

– Coordinate program integrity efforts of Plans

– Law Enforcement education and support
MEDIC
Investigators/Assignments

– Investigators are assigned to a specified geographic area and responsible for cases, contacts, and all other MEDIC activity in his/her assigned area

– Investigators are not centrally located; investigators typically reside in or near their area of responsibility

– There are 20 offices located in:
  – St. Augustine, Miami, Atlanta, Greensboro, New Orleans, Dallas, Houston, San Antonio, McAllen (TX), Denver, Kansas City, San Diego, Los Angeles, Easton (MD), Plymouth (PA), New Jersey, Boston, Chicago, Detroit, and Seattle.
Medicaid Integrity Contractors

- **Audit of Provider MICs** – post payment audits identify overpayments. State adjudication process used.

- **Review of Provider MICs** – identify audit leads to Audit MICs through claims data and algorithms.

- **Education MICs** – provide training and education to prevent fraud, waste and abuse.
# Who are the MICs

<table>
<thead>
<tr>
<th>Audit MICs:</th>
<th>Review of Provider MICs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Island Peer Review Organization (IPRO) Regions I &amp; II</td>
<td>AdvanceMed Corporation Regions V, VI, VII, VIII, IX &amp; X</td>
</tr>
<tr>
<td>Health Integrity Regions III, IV, V &amp; VII</td>
<td>Thomson Reuters Regions I, II, III, IV</td>
</tr>
<tr>
<td>Health Management Systems (HMS) Regions VI, VIII, IX &amp; X</td>
<td></td>
</tr>
</tbody>
</table>

**Education MICs:**

- Information Experts & Strategic Health Solutions LLC

For More Information: [http://www.cms.gov/MedicaidIntegrityProgram](http://www.cms.gov/MedicaidIntegrityProgram)
Resources
Regional Office Overview CMS Regional Offices

key messages. Development and maintenance of regional, state and local partnerships, including those with beneficiary coalitions, professional associations and governmental entities as well as an understanding of local influences enable ROs to gain access and build collaborative partnerships that might otherwise be impossible. These offices in the field also routinely collaborate with ROs of other Federal agencies to serve the health and human service needs of the public.

The CMS field is a conduit of information. These offices are constantly scanning and analyzing the regional, state and local health care marketplace and sharing their insights with central office. They not only represent the Agency on a grassroots level, they also represent the grassroots to the Agency. Information and data from the field contributes to informed policymaking and solutions that make sense inside and outside the bureaucracy.

Protection - The ROs put into practice on a regional, state and local level the protective regulations, policy and program guidance developed in central office. They ensure protections are in place to facilitate the delivery of high-value health care that is safe, effective, efficient, patient centered, timely and equitable.

ROs implement action at the local level to safeguard the health and well-being of our beneficiaries and the trust fund. Through ongoing customer service, patient advocacy and professional relations, they solve problems for beneficiaries, providers and other CMS stakeholders.

Monitoring - To achieve and maintain an affordable health care system, it is imperative that monitoring of CMS programs and evaluation of contracting practices is rigorous, accurate and timely. Through ongoing monitoring of State Medicaid Agency financial claiming, state survey agencies, Managed Care Plans, Medicare claims processing contractors and peer review organizations, the ROs are the Agency’s front line in monitoring the implementation of CMS policies and regulations.

Downloads
- Boston Regional Office (PDF, 132KB)
- New York Regional Office (PDF, 132KB)
- Philadelphia Regional Office (PDF, 132KB)
- Atlanta Regional Office (PDF, 132KB)
- Chicago Regional Office (PDF, 132KB)
- Dallas Regional Office (PDF, 132KB)
- Kansas City Regional Office (PDF, 132KB)
- Denver Regional Office (PDF, 132KB)
- San Francisco Regional Office (PDF, 132KB)
- Seattle Regional Office (PDF, 132KB)

Related Links Inside CMS
- Careers at CMS

Related Links Outside CMS
- There are no Related Links Outside CMS

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http://www.cms.gov/RegionalOffices/

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Health Care Fraud Prevention And Enforcement Action Team (HEAT)
Welcome to the Medicare Learning Network® (MLN) General Information Overview page, your destination for educational information on Medicare Fee-For-Service (FFS) providers.

As a result of changes in policy and legislation, Medicare providers may be uncertain as to what Medicare policy changes have occurred and how those changes apply to them. The MLN provides a variety of training and educational materials that break down Medicare policy into plain language. The MLN delivers planned and coordinated provider education through the various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

In the “Downloads” section you will find information on:

- MLN Products Catalog -- an interactive catalog that provides descriptions and links to all MLN educational products and resources.
- Provider Call Center Toll Free Numbers Directory -- a directory that offers Providers information on how to contact the appropriate Provider call center.
- MLN Video - Public Service Announcement -- 30 second introduction to the MLN.
- MLN Video - Quick and Basic Information about the MLN and its Benefits to Providers -- a 7 minute overview of the MLN.
- CMS Listservs Available for Medicare FFS Providers

In the "Related Links Inside CMS" section you will find links to the following:

- MLN Products
- MLN Product Ordering Page
- MLN Educational Web Guides
Resources

• Our websites:
  for consumers: www.medicare.gov
  for professionals: www.cms.gov
  Medicare Learning Network: www.cms.gov/MLNGenInfo/

• Fraud related:
  > www.stopmedicarefraud.gov
  > http://tinyurl.com/4dn6fwr (Medicare fraud factsheet)

• MAC Contacts for Providers: http://www.cms.gov/center/provider.asp and scroll down to the “Contacts” section - unzip the list of phone numbers, by state
Website Links

- **RAC**: http://www.cms.gov/RAC

- **QICs**: http://www.cms.gov/OrgMedFFSAppeals/03_ReconsiderationbyaQualifiedIndependentContractor.asp

- **QIOs**: http://www.cms.gov/QualityImprovementOrgs/

- **COB**: http://www.cms.gov/COBGeneralInformation/
Website Links

• **NSC:**
  http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

• **Medicaid Integrity Program:**
  http://www.cms.gov/MedicaidIntegrityProgram/
Questions ?
Importance of Documentation
Importance of Documentation

Program Integrity

Patient Safety

Provider Protection

DOCUMENTATION
Accurate Coding and Billing are Critical
Good documentation helps ensure quality patient care.
Fraudulent billings result in stiff penalties
New Technologies: Benefits and Vulnerabilities
NAME: 
SUBJECTIVE: LMP --- SMOKER: _______ Age: 17 Date: 7/28/06

Progress Note
Post MRI 7/1

Ultrasound showed NG & IUD help

Exam: BP 110/70 Ht 5'7 R 20 WT 180

General: O2GWN NAD EOMI --- No ictr/inf b/l ___TM's Clr ___ TH Clr

Neck: Supple ___ No LAN b/l ___ No JVD b/l ___ No Bruits b/l

Thyroid: ___ Nod Size ___ Symmetric ___ No nodules

Lungs: GTR b/l ___ No Wheeze b/l ___ No Ronchi b/l ___ No Rales b/l ___ Good aeration b/l

Heart: ___ RRR ___ No murmurs ___ No rubs ___ No ectopy

Abdomen: ___ Soft ___ No tenderness ___ No masses ___ No HSM

___ NABS ___ No guard ___ No rebound ___ No rigidity ___ No fl tenderness ___ No CVA tenderness

GU: ___ NEG ___ No Ingu LNM ___ No ureth/vag d/c ___ no ext lesions ___ no testicular masses ___ No hemia

Breasts:

Extremities: ___ No clubbing ___ No cyanosis ___ No edema

Back:

Neurological: ___ 2/1 DTR b/l u/s ext. ___ 5/5 str throughout. ___ EOMI ___ Babinski ___ Neg Rhomb Ceg

___ rapid/face all hand mvt b/l, ___ nmt FN coord b/l, ___ nmt gait, ___ nmt toe walk, ___ nmt heel walk

Integument: ___ nmt color, ___ nmt turgor, ___ No concerning rash/lesions. ___ No diaphoresis

AP: Clear voice

Pulse 72 BP 110/70 17.61 > refer once

Long talk & fl of JCN no poor prog

Reg relief & frd wlk

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HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM (HEAT)
Non-Contemporaneous Entries

PROGRESS NOTE
NAME: [Redacted]
SUBJECTIVE: LMP — SMOKER: Y

General: VWDN — NAD
ENT: NCA[2] — PERRL — EOMI — No ic/inj b/l — TMs C1 — TH C1
Neck: Supple — No LAN b/l — No JVB b/l — No Bruits b/l
Thyroid: Nml Size — Symmetric — No nodules
Lungs: — No Wheeze b/l — No Ronchi b/l — No Rales b/l — Good aeration b/l
Heart: — FRR — No murmurs — No rubs — No ectopy
Abdomen: Soft — No tenderness — No masses — No HSM — NABS — No guard — No rebound — No rigidity — No fl tenderness — No CVA tenderness
GU: NEG — No ina LAN — No ureth/vaac d/c — No ext lesions — No testicular masses — No hernia
Breasts:
Extremities: — No clubbing — No cyanosis — No edema
Back:
Neurological: — 2/4 DTR b/l — u/l ext. — S/S str throughout — EOMI — Babinski — Neg Rhomberg — rapid/acc alt hand mvt b/l — nml FN coord b/l — nml gait — nml toe walk — nml heel walk
Integument: — nml color — nml turgor — No concerning rash/lesions — No diaphoresis

AP:

CBC — PT/PTT/INR — XRAY
CMP/AMP — EKG/ST
TSH/PT4 — SONO
HGA/BS — ECHO
PLP/LFT — MAMMO
DGA — UROCHE

[Handwritten note:]

Long talk / phy. exam / No prob found / refer one.

[Handwritten note:]

Pain relief / No leg swelling
Subpoenas, Audits, and Surveys
• An IG subpoena is as “real” as any court-issued subpoena

• Do not ignore the subpoena
Audits and Surveys

• Audits by the OIG’s Office of Audit Services

• Studies by the OIG’s Office of Evaluation and Inspections

Participation is important
Self-Disclosure
Self-Disclosure
Self-Disclosure

Should I disclose?

Where should I disclose?
- Contractor
- OIG
- DOJ
- CMS

Get some advice
OIG Self-Disclosure Protocol

Include all the Information

Consult OIG’s website
Resolution

- OIG = Civil Monetary Penalties law settlement
- DOJ = False Claims Act settlement
- No Corporate Integrity Agreement if cooperative
Break
Understanding the Consequences of Health Care Fraud

**Moderator:**
Spencer Turnbull  
OIG HEAT Initiative Administrator

**Panelists:**
Dr. Peter Budetti  
Deputy Administrator and Director  
Center for Program Integrity, CMS

Nick DiGiulio  
Special Agent in Charge  
OIG Office of Investigations Region 3

John Pease  
Assistant United States Attorney  
Eastern District of Pennsylvania

Jacqueline Franklin  
Supervisory Criminal Investigator  
Medicaid Fraud Control Unit of Washington, D.C.
Closing Remarks
Thank You for Attending the HEAT Provider Compliance Training