AMERICAN BAR ASSOCIATION
Health Law Section

THE HEALTH LAWYER

IN THIS ISSUE

Volume 27, Number 6,
August 2015

THE ALPHABET SOUP OF MEDICARE AND MEDICAID CONTRACTORS

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Introduction

Healthcare providers, suppliers, and their staff, as well as attorneys representing healthcare entities are faced regularly with a barrage of private contractors tasked with a variety of responsibilities for administering the Medicare program, including claims processing, reimbursement, enrollment and auditing activities. Given the number of different contractors (and different acronyms, for that matter), it can be difficult to identify the role of the particular contractor one is dealing with, the focus or goal of the program the contractor is involved in and the responsibilities it is tasked with managing, as well as the statutory and regulatory scope of its authority. This article seeks to identify the various Medicare and Medicaid contractors and outline their authority, focus and responsibilities.

Medicare Contractors

Contracting with private entities has been a part of the Medicare program since its inception. When Medicare was enacted in 1965, there were concerns over the government's intrusion into the healthcare affairs of Americans, so Congress provided for the Medicare program to be administered primarily by private entities that were already engaged in the health insurance business. Section 1874 of the Social Security Act ("SSA") states that "[e]xcept as otherwise provided, the Secretary may perform any of his functions under Title 18 directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary."[1] This contracting authority allows for the use of private entities to administer various aspects of the Medicare program.

Claims Processing Contractors

Fiscal Intermediaries and Carriers

Prior to the advent of the Medicare Administrative Contractors ("MACs"), discussed below, Medicare claims were processed by fiscal

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GOVERNMENT HIGHLIGHTS NEW FOCUS ON PHYSICIAN FRAUD

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The concept of individual liability for healthcare fraud was dramatically highlighted in the recent Medicare Fraud Strike Force announcement of charges against over 200 individuals, many of which were doctors and nurses.[1] The charges against the licensed medical professionals included allegations of improper billing for unnecessary services, for services not provided as represented and/or for services not provided at all.[2]

While the Strike Force takedown stands as a spectacular example of the potential for individual liability, much more common are announcements which tend to put the focus on institutional provider liability. Recently, it was a South Florida nursing home provider that grabbed the headlines when it paid a record-setting $17 million to settle a False Claims Act ("FCA") suit.[3] While it was the provider's multi-million pay-out that put it into the spotlight, the underlying allegations of wrongdoing involved medical director arrangements which implicated both the provider and the cooperating doctors.[4] And while the settlement offered some closure for the nursing home provider, the potential liability of the doctors was not released by the providers' settlement – the fate of the doctors remains to be determined. In the face of repeated examples of provider-focused news flashes, legal advisors would do well to remember that criminal, civil and administrative sanctions are not reserved for the institutional providers involved in federal healthcare program fraud – physicians and other licensed professionals most certainly share in the risks and responsibilities that come with participation in the healthcare delivery system.

2015 Physician-Focused Fraud Alert

The Department of Health and Human Services' Office of Inspector General ("OIG") recently reaffirmed its ability to and willingness to go after the physicians involved in questionable compensation arrangements in a June 2015 Fraud Alert in which it announced the potential for "significant liability" to attach to physicians.[5] The OIG alluded to recent settlements with doctors who were found to be "an integral part" of an offending "scheme" and, therefore, subject to liability under the Civil Monetary Penalties Law ("CMPL").[6]

In its June 2015 Fraud Alert, the OIG appears to spotlight a succession of claims it has pursued against individual physicians in the aftermath of the well-publicized case against Dr. Jack L. Baker, a prominent Houston radiologist accused of paying illegal compensation to doctors to induce them to refer patients to an imaging center he owned and operated. Dr. Baker settled the matter several years ago, paying a $650,000 FCA settlement which included his multi-year exclusion from federal healthcare program participation.[7] The Fraud Alert lets industry observers know that, in addition to the FCA settlement with the facility and its owner, the OIG also pursued the doctors who were parties to the medical director deals. Through so-called "spin-off" CMPL cases, the OIG went after a dozen of the physicians who had signed on to the questionable medical director agreements. By one account, the OIG is reported to have collected over $1.4 million in penalties from 11 physicians and excluded one physician for three years. Individual doctors reportedly paid from $50,000 to $195,016 to settle the claims.[8]

In its Fraud Alert, the OIG emphasized that a duty falls on the physician to ensure that compensation arrangements are based on fair market value for *bona fide* services actually provided. The bottom line for doctors is that improper financial arrangements give rise to personal risk of physician liability under the Anti-Kickback Statute ("AKS"). The OIG used its Fraud Alert to remind physicians of the "one-purpose" standard under which an arrangement may violate the AKS if even just one purpose of the arrangement is to compensate the doctor for referrals of federal healthcare program business.[9] Offending payments to medical directors may include payments which take into account the volume or value of referrals, compensation which exceeds fair market value or disbursements which reward doctors for services not actually furnished. Moreover, the payment need not be direct. For instance, when an entity receiving physician referrals steps in to pay office staff salaries that would have otherwise been the obligation of the physician, those payments can be considered illegal remuneration to the physician; it is not only the entity but the physician that is subject to liability.[10]

Physician-Focused Enforcement Activity

When an institutional provider is called up on allegations of unlawful activity, it is increasingly clear that the participating physicians and physician family members will not be overlooked by government investigators. In the fall of last year, A Plus Home Health Care Inc. and its owners paid $1.65 million to settle allegations that the company paid spouses of referring physicians for sham marketing positions in order to induce patient referrals.[11] The company allegedly hired at least seven physicians' spouses and one physician's boyfriend to perform marketing duties,

but required the spouses and boyfriend to perform few, if any, actual job duties. Instead, the spouses' and boyfriend's salaries allegedly served as an inducement and reward for the physicians' referrals of Medicare patients to the company. Apart from its $1.65 million settlement with the company, the government separately pursued and ultimately settled with five of the couples that allegedly accepted the offending payments.[12]

Claims of physician liability can be more subtle than the glaring fraud claims showcased in the recent takedown *tour de force*. In *United States ex rel. Barker v. Tidwell*, decided June 2015, a *qui tam* relator leveled charges against Dr. Thomas Tidwell, including a claim that Dr. Tidwell submitted False Claims when his billings for services followed a sale of his Cancer Treatment Center to the local hospital for an allegedly inflated price.[13] The relator claimed – and Dr. Tidwell did not dispute – that compliance with the AKS is necessary for reimbursement of Medicare and Medicaid claims.[14] Indeed, federal law provides that a claim that includes items or services resulting from a violation of the AKS constitutes a false or fraudulent claim.[15] The Court in the *Tidwell* case concluded that the question of whether the doctor's price for his Cancer Treatment Center was in excess of fair market value was a question for the jury; if the jury found the amount paid exceeded fair market value, the jury was free to find that excess payment to be a kickback for referrals and an AKS violation.[16] The *Tidwell* case is yet another example of cases which have made clear that it is the physicians – not just the hospitals or other institutional providers – that face the potential for liability for AKS violations.

Lessons Learned

In the face of recent enforcement activity and the latest Fraud Alert guidance, physicians are well-advised to strengthen efforts to prevent and reduce improper conduct. The OIG has long admonished both solo and group practice doctors to proactively implement procedures that begin with auditing and monitoring for compliance; the lessons taught over a decade ago in the OIG Compliance Program notice still stand as sage advice for practicing physicians.[17] With online podcasts and annual Work Plan updates, the OIG constantly renews and refreshes its long-standing emphasis on the compliance initiatives it expects from health industry participants. And, acknowledging the 2010 Patient Protection and Affordable Care Act ("PPACA") call for a mandate on healthcare compliance plans, there is near-universal agreement on the wisdom of adopting a conforming compliance plan without delay.

Compliance Specifics

The OIG recommends that all physician practices periodically review the standards and procedures that govern on-going office operations.[18] Ineffective and outdated approaches should be eliminated or updated to reflect not only regulatory requirements but all of the latest in published guidance.[19] Employee background check procedures that go unobserved or that fail to meet current expectations are among the many potential failures in process that can give rise to liability. Following a recent OIG investigation, on June 1, 2015, two providers agreed to pay $100,000 for allegedly violating the CMPL by employing individuals excluded from participation in federal healthcare programs.[20] Such examples of recent enforcement activity highlight the importance of avoiding common pitfalls by using best practices such as fingerprint-based background checks and employee screening.[21] Because of seemingly continuous changes, physicians (and other providers) must remain vigilant to know what constitutes current compliance. Changes in applicable requirements can be issued through manuals, alerts and published guidance; providers are expected to know and observe new mandates imposed at the state or federal levels.

Billing and Coding

A baseline audit examination should include a thorough look at how claims are developed and submitted; periodic audits should follow at least annually to ensure ongoing compliance. The OIG recommends an initial review of at least five medical records for each federal payor source (such as Medicare and Medicaid) and at least five or ten medical records per physician. Time-based codes such as those common in oncology practices should be supported by documentation of admission time and discharge time; records should be analyzed for compliance with applicable requirements such as the necessity to address multiple systems to support a comprehensive history. The record review should focus on the codes billed and reimbursed, the accuracy of the orders, the services performed and the reasonableness and necessity of all services.[22]

Arrangements with Other Providers

Because billing, coding and claims submission are only a part of the compliance picture, physician practices must extend their compliance initiatives to include an analysis of AKS and Stark Law issues.[23] They should know the specifics of any and all existing arrangements with other doctors and with outside entities including hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, pharmacies, laboratories and vendors.[24] A physician group may have a long-standing renewable lease arrangement with the local hospital and may merely assume that the hospital's lawyers developed the lease terms to meet applicable requirements; perhaps years have passed since the doctors reviewed

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those terms. For its own protection, a doctor group leasing space from the local hospital should have its own counsel evaluate the lease to ensure its terms – including pricing – are current, appropriate and fully conforming to the applicable safe harbor provisions.[25] Any office or equipment lease with an entity to which the physician refers should be pulled, reviewed and amended as necessary for the protection of the physician group.[26]

The Compliance Take-Away

Civil FCA liability can arise under circumstances in which the physicians' behavior shows deliberate ignorance or reckless disregard; whistleblower suits open the door for anyone willing to allege FCA liability.[27] For physician protection, compliance training and billing/coding training must be a recurring feature of any ongoing physician practice operation.[28] Training should focus on the importance of compliance, the consequences of violations, the key standards and procedures of the group and the role of all staff in ensuring compliance. Billing/coding training should include a review of current requirements, an examination of the claims development and submission processes and a review of documentation policies. Training for all individuals involved in billing and coding is a must and should be offered at least annually.[29] Ensuring appropriate responses to detected offenses is critical for compliance, as are measures which ensure open lines of communication.[30] Doctor groups should take seriously the "grumblings" of any current or former employee that appears "disgruntled" and should respond diligently, promptly and thoroughly to even the most routine records requests. Core compliance concerns should be raised in any situation involving the provision of free or below-market goods or services to a physician who is a source of referrals. The companion concern arises with payments to referring physicians in excess of fair market value.[31]

Responding to Enhanced Scrutiny

Despite what can appear to be a focus on institutional provider liability, individual professionals participating in healthcare delivery must remain vigilant and cognizant of the risk of criminal, civil and administrative sanctions. Many compliance-related concerns exist not only for physicians but also for psychologists, physical therapists, speech language pathologists, occupational therapists and other independent practitioners.[32] The reality in healthcare today is that liability extends beyond the institutional provider; through its most recent Fraud Alert and its enforcement activities, the OIG has made it clear that physician groups and individual participants in wrong-doing will be separately called to answer for alleged liability. In response, practitioners should ensure not only the existence of but the continued viability of their compliance plans.

Joy Heath, J.D., is a healthcare attorney focused on business and regulatory matters for provider clients. For nearly thirty years, Ms. Heath has enjoyed working with providers to reduce risk and enhance operations through improved compliance strategies and business initiatives. Ms. Heath is a partner with Williams Mullen in its downtown Raleigh, North Carolina office. She can be reached at (919) 559-3904 and *jheath@williamsmullen.com*.

Endnotes

1 http://hhs.gov/news/press/2015pres/06/20150618a.html. According to the Office of Inspector General's website, "Medicare Fraud Strike Force Teams harness data analytics and the combined resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. First established in March 2007, Strike Force teams currently operate in nine areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; southern Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas." https://oig.hhs.gov/fraud/strike-force.

2 *Id.*

3 http://law360.com/articles/668702/miami-nursing-home-to-pay-record-17m-in-whistleblower-suit.

4 *Id.*

5 https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf.

6 The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to: (1) knowingly presenting or causing to be presented a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal healthcare program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal healthcare program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal healthcare program beneficiary; or (6) using a payment intended for a federal healthcare program beneficiary for another use. 42 U.S.C. § 1320a-7a.

7 http://justice.gov/archive/usao/txs/1News/Releases/2012%20August/120814%20Baker.html.

8 http://mwe.com/Recent-DOJ-and-OIG-Actions-Show-Growing-Federal-Scrutiny-of-Physician-Financial-Arrangements-07-01-2015.

9 If even one purpose of a payment is to induce future referrals, the Medicare statute has been violated. *See* 42 U.S.C. § 1395nn(b)(2); *United States v. Greber*, 760 F.2d 68, 69 (3d Cir. 1985).

10 *Id.*

11 http://justice.gov/opa/pr/florida-home-health-care-company-and-its-owners-agree-resolve-false-claims-act-allegations.

12 *Id.*

13 *U.S. ex rel. Barker v. Tidwell*, No. 4:12-CV-108

CDL, 2015 WL 3505554, (M.D. Ga. June 3, 2015); The FCA permits private citizens, known as "relators," to file a civil action on behalf of the government to recover money that the government paid on account of false or fraudulent claims. 31 U.S.C. § 3730(b)(1). These actions are referred to as *qui tam* actions. "To establish civil liability under the [FCA], a relator generally must prove (1) that the defendant made a statement in order to receive money from the government; (2) that the statement was false; and (3) that the defendant knew the statement was false." *See United States ex rel. Bellevue v. Universal Health Servs. of Hartgrove Inc.*, No. 11 C 5314, 2015 WL 1915493 (N.D. Ill. Apr. 24, 2015).

14 *U.S. ex rel. Barker v. Tidwell*, No. 4:12-CV-108 CDL, 2015 WL 3505554, at *3 (M.D. Ga. June 3, 2015).

15 42 U.S.C.A. § 1320a-7b(g).

16 *Id.*

17 65 Fed. Reg. 59434 (Oct. 5, 2000).

18 65 Fed. Reg. 59434, 59437 (Oct. 5, 2000).

19 *Id.*

20 P & S Healthcare Management, LLC, the former general partner of Woodland Springs Healthcare, LP and P & S Healthcare, LP (P & S) agreed to pay $100,000 for allegedly violating the CMPL. The OIG alleged that Woodland Springs employed an individual who was excluded from participating in any federal healthcare programs. OIG also alleged that P & S employed two individuals who were excluded from participating in any federal healthcare programs. The OIG's investigation revealed that these excluded individuals provided items and services to federal healthcare program beneficiaries. https://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp.

21 https://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp.

22 *Id.*

23 The federal self-referral statute commonly known as the Stark Law, 42 U.S.C. § 1395nn, broadly prohibits physicians from making certain referrals to entities with which they have a financial relationship unless a statutory exception applies.

24 65 Fed. Reg. 59434, 59440 (Oct. 5, 2000).

25 Similar to the AKS, the Stark Law has specific requirements which apply to office space rental arrangements with referring physicians. To fit within the safe harbor provisions, a lease for office space must meet specific requirements. 42 U.S.C. § 1395nn(e)(1); *See also* 42 C.F.R. § 411.357(a)(4).

26 65 Fed. Reg. 59434, 59441 (Oct. 5, 2000).

27 31 U.S.C. §§ 3729 – 3733; *See also "Avoiding Medicare and Medicaid Fraud and Abuse,"* U.S. Department of Health & Human Services, Office of Inspector General.

28 65 Fed. Reg. 59434, 59442 (Oct. 5, 2000).

29 65 Fed. Reg. 59434, 59443 (Oct. 5, 2000).

30 *Id.*

31 *Id.*

32 65 Fed. Reg. 59434, 59435 (Oct. 5, 2000).