Federal Fraud and Abuse Laws

Remaining in Compliance while Attesting to Meaningful Use

A project of L.A. Care Health Plan
Overview

• This presentation provides an overview of key Federal laws aimed at preventing healthcare fraud and abuse in order to give physicians a better understanding of how to remain in compliance while participating in the Meaningful Use program.
Compliance

• **Do the right thing** because...
  
  – Otherwise you
    • go to jail
    • pay fines
    • lose your license
  
  – *It is the right thing to do*
The Problem / The Solution

• By some estimates, fraud and abuse cost the taxpayers between $30 billion and $100 billion each year.

• The Federal government’s efforts to recover money from fraud cases pays off:
  – For every $1 dollar invested in audit/recoupment activities, the government recovers $6 dollars.
  – More enforcement efforts are built into ACA.
Fraud, Waste and Abuse

• FRAUD
  – Includes obtaining something of value through intentional misrepresentation or concealment of material facts
Fraud, Waste and Abuse

• WASTE

- Includes incurring unnecessary costs as a result of deficient management, practices, systems, or control
Fraud, Waste and Abuse

• ABUSE
  – Includes any practice inconsistent with providing patients with
    • Medically necessary services
    • Services that meet professionally recognized standards
    • Services that are priced fairly
Roadmap

• The Office of Inspector General (OIG) often talks about anti-fraud laws as the “road signs” alerting you of hazards along the way
• Because you are treating Medicare and/or Medicaid beneficiaries, you must understand and obey these road signs.
• OIG provides Compliance Guidance, including a free publication entitled “A Roadmap for New Physicians: Avoiding Medicare/Medicaid Fraud”
Federal Fraud and Abuse Laws

- Physician Self-Referral Statute (Stark)
- Anti-Kickback Statute (AKS)
- False Claims Act (FCA)
- Exclusion Statute
- Civil Monetary Penalties Law (CMP)
Physician Self-Referral Statute

- Prohibits referral of a Medicare patient by a physician for designated health services to an entity with which the physician, or an immediate family member, has a financial relationship
  - EXCEPTIONS apply
Anti Kickback Statute

- Prohibits asking for or receiving anything of value to induce or reward referral of Federal program business
  - SAFE HARBORS apply
Stark & AKS – Meaningful Use

• Congress has passed legislation that provides hospitals an exception to the restrictions of the Stark and Anti-Kickback laws.
  – allows hospitals to donate “Items and services necessary and used predominantly to create, maintain, transmit, or receive EMRs” to community or affiliated physicians.
  – Sunsets December 2013
False Claims Act

• It is illegal to submit false or fraudulent claims for payment to the Federal government
  – Expanded to include Healthcare claims
  – Includes deliberate ignorance and reckless disregard of the truth
  – Includes retention of overpayments
• Contains “Whistle Blower” provisions
FCA – Meaningful Use

• The Meaningful Use attestation is a claim for payment
  – Eligible Professionals (EP) have to demonstrate meaningful use through CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System
  – EP will fill in numerators and denominators for the meaningful use objectives and clinical quality measures (CQMs), indicate if they qualify for exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use
  – Once EP has completed a successful online submission through the Attestation System, they may qualify for a Medicare EHR incentive payment
FCA – Meaningful Use

• Attestation Statements:
  – The information submitted for CQMs was generated as output from an identified certified EHR technology
  – The information submitted is accurate to the knowledge and belief of the EP (or the person submitting on behalf of the EP)
  – The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EP
  – The information submitted includes information on all patients to whom the measure applies
Exclusion Statute

• 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
  – Mandatory
  – Permissive
Civil Monetary Penalties Law

• OIG can use Civil penalties for a variety of reasons
  – For submitting a false claim
  – For employing an excluded individual
Compliance Program

• A compliance plan helps establish policies and procedures to prevent fraud and abuse
• Utilize Federal Sentencing Guidelines
• Written policies not enough
Compliance Program for Individual and Small Group Practices

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards
Q & A

Ralph Oyaga, Esq., MBA
Associate Counsel
(213) 694-1250 x4182
Email: royaga@lacare.org
www.hitecla.org