COMPLIANCE CONNECTION

APRIL 2024

This newsletter is prepared monthly by the Midland Health Compliance Department and is intended to provide relevant compliance issues and hot topics.

IN THIS ISSUE

FRAUD & ABUSE LAWS

The five most important Federal Fraud and Abuse Laws that apply to physicians are:

1. ***False Claims Act (FCA):*** *The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.*
2. ***Anti-Kickback Statute (AKS):*** *The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).*
3. ***Physician Self-Referral Law (Stark law):*** *The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.*
4. ***Exclusion Statute:*** *OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.*
5. ***Civil Monetary Penalties Law (CMPL):*** *OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation.*

Resource:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

MIDLAND HEALTH

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Pharmacy Owner and Operations Manager Convicted of $2.3M Ohio Medicaid Fraud

A federal jury convicted an Ohio pharmacist and his operations manager, a pharmacy technician, yesterday for conspiring to defraud Ohio's Medicaid program.

According to court documents and evidence presented at trial, Nathanael Thompson, 45, of Westerville, owned four pharmacies in Columbus, Ohio. Sanam Ahmad, 34, of Galena, managed the pharmacies. Thompson and Ahmad conspired to charge Medicaid for a particular manufacturer's omeprazole, a type of proton pump inhibitor, which was reimbursable at a significantly higher rate than most omeprazole. In reality, the dispensed medication was generic omeprazole purchased at big-box warehouse retail stores. In addition, to maximize profits, Thompson's pharmacies put in place certain protocols to dispense omeprazole as though a doctor had prescribed the drug even when there was no prescription.

The jury convicted Thompson and Ahmad of one count of conspiracy to commit health care fraud and two counts of defrauding Medicaid. They face a maximum penalty of 10 years in prison on the conspiracy charge and each health care fraud charge. A sentencing date has not yet been set. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Acting Assistant Attorney General Nicole M. Argentieri of the Justice Department's Criminal Division, U.S. Attorney Kenneth L. Parker for the Southern District of Ohio, Special Agent in Charge Orville O. Greene of the Drug Enforcement Administration (DEA) Detroit Division, Acting Special Agent in Charge Cheryl Mimura of the FBI Cincinnati Field Office, Special Agent in Charge Mario M. Pinto of the Department of Health and Human Services Office of Inspector General (HHS-OIG) Chicago Region, Special Agent in Charge Jeff Krafels of the U.S. Postal Service Office of Inspector General (USPS-OIG) Mid-Atlantic Area Field Office, Ohio Attorney General Dave Yost, and Director Steven W. Schierholt of the State of Ohio Board of Pharmacy Executive made the announcement.

The DEA, FBI, HHS-OIG, USPS-OIG, Ohio Medicaid Fraud Control Unit, and the State of Ohio Board of Pharmacy investigated the case.

Read entire article:
https://www.justice.gov/opa/pr/pharmacy-owner-and-operations-manager-convicted-23m-ohio-medicaid-fraud

MIDLAND HEALTH Compliance HOTLINE
855•662•SAFE (7233)
ID#: 6874433130
ID# is required to submit a report.
You can make your report or concern ANONYMOUSLY .

MIDLAND HEALTH

MIDLAND HEALTH POLICYTECH

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MIDLAND HEALTH CODE OF CONDUCT

Purpose: Midland Memorial Hospital ("MMH") is committed to conducting business in an ethical and honest manner and within the bounds of the law. This Code of Conduct provides governing board members, medical and allied health staff, employees, agency staff, independent contractors, vendors, volunteers and students of Midland Memorial Hospital ("MMH Representatives") with guidelines for conducting business and operations in a manner which fulfills this commitment. This Code of Conduct further provides the foundation principals for implementing the MMH Compliance Program, which serves to prevent the occurrence of illegal or unethical behavior, and is supplementary to the mission, vision, and values of MMH, its policies and procedures, as well as pertinent state and federal law.

This Code of Conduct has been distributed to all MMH Representatives and sets forth general standards applicable to all MMH business and operations. In addition to this Code of Conduct, there are a number of more detailed and specific MMH policies and procedures covering the particular issues described herein.

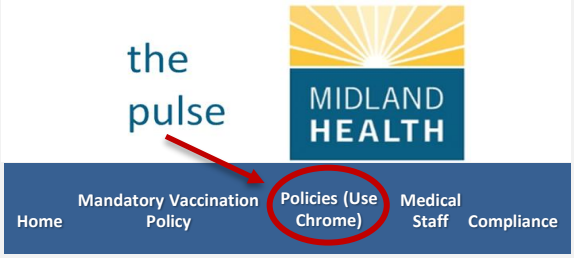
Policy

- MMH's Commitment to Legal and Ethical Behavior
- Complying with the Law
- Providing for Excellent Patient Care
- Protecting Confidential Information
- Adhering to Anti Kickback and Healthcare Fraud and Abuse Legislation
- Declining Inappropriate Gifts or Gratuities
- Policy Pertaining to Business Courtesies Received from Vendors
- Not Providing Inappropriate Gifts to Patients and Visitors
- Avoiding Conflicts of Interest

Read entire Policy:
Midland Health PolicyTech #3755 – "Code of Conduct"

Midland Health PolicyTech Instructions

Click this link located on the Midland Health intranet "Policies"
https://midland.policytech.com/dotNet/noAuth/login.aspx?ReturnUrl=%2f



IN OTHER COMPLIANCE NEWS

LINK 1

Malicious Insider Incident at Montefiore Medical Center Results in $4.75 Million HIPAA Penalty

https://www.hipaajournal.com/montefiore-medical-center-malicious-insider-hipaa-penalty/

LINK 2

Indiana Attorney General Files Lawsuit Against Apria Healthcare Alleging HIPAA Violations

https://www.hipaajournal.com/indiana-attorney-general-lawsuit-apria-healthcare/

LINK 3

OCR Reports to Congress on HIPAA Compliance and Data Breaches

https://www.hipaajournal.com/ocr-reports-to-congress-on-hipaa-compliance-and-data-breaches/

LINK 4

CMS Updates Policy to Allow Texting Patient Information and Patient Orders

https://www.hipaajournal.com/cms-updated-policy-texting-patient-information-orders/

KICKBACKS AND UNNECESSARY TESTING

Georgia Laboratory Owner Pleads Guilty to Felony Charge and Pays $14.3 Million to Resolve Liability Relating to Kickbacks and Unnecessary Testing

Kickbacks Paid to Sell Unnecessary Urine Drug Tests for At-Risk Children and Respiratory Pathogen Panels for Seniors Receiving COVID Tests

Andrew (Drew) Maloney, 57, of Roswell, Georgia, has pleaded guilty to a criminal information charging him with conspiracy to pay health care kickbacks, the Justice Department announced today. Additionally, Maloney and the clinical laboratory that he owned, Capstone Diagnostics, of Atlanta, Georgia, have agreed to pay $14.3 million to resolve allegations that they violated the Anti-Kickback Statute by paying volume-based commissions to independent contractor sales representatives to arrange for or recommend medically unnecessary urine drug tests and respiratory pathogen panels (RPPs). Maloney and Capstone have agreed to cooperate with the Justice Department's investigations of other participants in the alleged schemes.

As alleged in the criminal information filed in the Northern District of Georgia, between August 2017 and December 2018, Capstone entered into an arrangement with a program operating as Do It 4 the Hood (D4H), which held itself out as providing after school mentoring services to at risk teenagers in Georgia. Once enrolled, participants were required to submit to frequent urine specimen collections for drug testing without regard to medical need or the history of the participant. Maloney was aware that the participants needed the tests to participate in the program and that many of these participants were covered by Medicaid. Capstone, with Maloney's knowledge and approval, paid the operators of D4H a percentage of Medicaid reimbursements for samples submitted by the program, in violation of federal law. While the scheme was ongoing, Capstone submitted over $1 million in claims, causing Georgia Medicaid to pay out at least $400,000 in claims related to the fraudulent drug testing. In addition to Maloney's guilty plea, four other individuals have pleaded guilty in connection with this fraudulent drug testing scheme.

Read entire article:
https://www.justice.gov/opa/pr/georgia-laboratory-owner-pleads-guilty-felony-charge-and-pays-143-million-resolve-liability

HHS OIG EXCLUSION LIST

What Does it Mean To Be On the HHS OIG Exclusion List?

If an individual or organization is on the HHS OIG Exclusion List, it means they been excluded from participating in Federally funded healthcare programs such as Medicare and Medicaid; and not only can they not bill the programs directly for goods or services, their goods or services cannot be acquired by any other healthcare provider that participates in a Federal healthcare program.

In 1977, the Medicare-Medicaid Anti-Fraud and Abuse Amendments mandated that healthcare practitioners who were convicted of a criminal offense against Medicare or Medicaid (i.e., under the False Claims Act) should be excluded from participating in Medicare and Medicaid "for such period as [the Secretary for Health and Human Services] deems appropriate".

The exclusion clause (§ 1128A of the Social Security Act) was extended by the Civil Monetary Penalties Law in 1981 to cover all individuals and organizations that submit false, fraudulent, or otherwise improper claims to Medicare or Medicaid; and extended again by HIPAA in 1996 to prohibit excluded individuals and organizations from participating in any Federal healthcare program.

Read entire article:
https://www.hipaajournal.com/what-does-it-mean-to-be-on-the-hhs-oig-exclusion-list/

Do you have a hot topic or interesting Compliance News to report?

If so, please email an article or news link to:

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