COMPLIANCE CONNECTION

FEBRUARY 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 EXAMPLES

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

1. ***False Claims Act (FCA):*** *A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than actually provided.*
2. ***Anti-Kickback Statute (AKS):*** *A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals.*
3. ***Physician Self-Referral Law (Stark law):*** *A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest.*
4. ***Exclusion Authorities:*** *Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.*
5. ***Civil Monetary Penalty Law (CMPL):*** *Includes making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.*

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

MIDLAND HEALTH

COMPLIANCE TEAM

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Indiana Health Network Agrees to Pay $345 Million to Settle Alleged False Claims Act Violations

Community Health Network Inc. (Community), a health care network headquartered in Indianapolis, has agreed to pay the United States $345 million to resolve allegations that it violated the False Claims Act by knowingly submitting claims to Medicare for services that were referred in violation of the Stark Law.

The Stark Law seeks to safeguard the integrity of the Medicare program by prohibiting a hospital from billing for certain services referred by physicians with whom the hospital has a financial relationship, unless that relationship satisfies one of the law's statutory or regulatory exceptions. Under the Stark Law, when a hospital employs a physician, the hospital may not submit claims for certain services referred by that physician unless the physician's compensation is consistent with fair market value and not based on the value or volume of their referrals to the hospital. In this lawsuit, the United States alleged that the compensation Community paid to its cardiologists, cardiothoracic surgeons, vascular surgeons, neurosurgeons and breast surgeons was well above fair market value, that Community awarded bonuses to physicians that were tied to the number of their referrals, and that Community submitted claims to Medicare for services that resulted from these unlawful referrals.

The United States' complaint alleged that beginning in 2008 and 2009, senior management at Community embarked on an illegal scheme to recruit physicians for employment for the purpose of capturing their lucrative "downstream referrals." Community successfully recruited hundreds of local physicians, including cardiovascular specialists, neurosurgeons and breast surgeons, by paying them salaries that were significantly higher — sometimes as much as double — what they were receiving in their own private practices. Community was well aware of the Stark Law requirements that the compensation of employed physicians had to be fair market value and could not take into account the volume of referrals. Community hired a valuation firm to analyze the compensation it proposed paying to its recruited specialists. The complaint alleged that Community knowingly provided the firm with false compensation figures so that the firm would render a favorable opinion. The complaint further alleged that Community ignored repeated warnings from the valuation firm regarding the legal perils of overcompensating its physicians. In addition to paying specialists excessive compensation, the complaint alleged that Community awarded incentive compensation to physicians, in the form of certain financial performance bonuses that were based on the physicians reaching a target of referrals to Community's network, again in violation of the Stark Law.

Read entire article:
https://www.justice.gov/opa/pr/indiana-health-network-agrees-pay-345-million-settle-alleged-false-claims-act-violations

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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HIPAA Section 13: Receiving and Resolving Complaints

POLICY

MIDLAND MEMORIAL HOSPITAL shall have a process by which any person can make a complaint to MIDLAND MEMORIAL HOSPITAL or the Secretary of the Department of Health and Human Services ("Secretary") regarding MIDLAND MEMORIAL HOSPITAL's privacy policies, procedures, and/or practices, as well as MIDLAND MEMORIAL HOSPITAL's compliance with its privacy policies and procedures and the Privacy Standards. MIDLAND MEMORIAL HOSPITAL employees whose responsibilities include receiving and/or responding to complaints shall be familiar with this policy and shall follow these procedures.

PROCEDURE

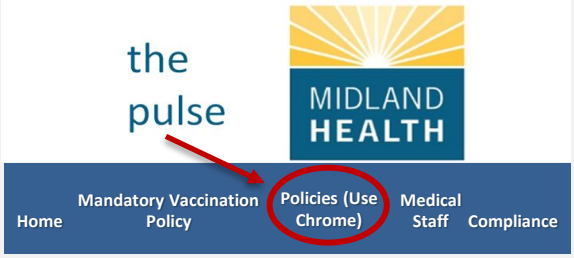
Designation of Contact Person. All complaints will be forwarded to the Privacy Officer in accord with HIPAA Section 2: Privacy Officer. The Privacy Officer will be responsible for receiving complaints relating to: (a) privacy policies, procedures, and/or practices; (b) compliance with its policies and procedures; and (c) compliance with the Privacy Standards. The Privacy Officer's responsibilities also include investigating and resolving complaints, as well as providing information to persons who request additional information about matters addressed in the Notice of Privacy Practices ("Notice").

Inform Persons of Their Right To Complain. In accordance with HIPAA Section 4.1: Notice , the Notice shall inform persons that they may complain to MIDLAND MEMORIAL HOSPITAL and/or to the Secretary if they believe their privacy rights have been violated. The Notice shall identify the Privacy Officer or office for receiving complaints and give a brief description of how the person may file a complaint with MIDLAND MEMORIAL HOSPITAL. The Notice shall also contain a statement that the person will not be retaliated against for filing a complaint.

Read entire Policy: Midland Health PolicyTech #2935
"HIPAA Section 13: Receiving and Resolving Complaints*"*

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

Delta Dental of California Data Breach: 7 Million Individuals Affected

https://www.hipaajournal.com/delta-dental-california-data-breach/

LINK 2

Healthplex Settles Data Breach Investigation with NY Attorney General for $400,000

https://www.hipaajournal.com/healthplex-data-breach-settlement-new-york/

LINK 3

HIPAA Updates and HIPAA Changes in 2023-2024

https://www.hipaajournal.com/hipaa-updates-hipaa-changes/

LINK 4

Can A Patient Sue for A HIPAA Violation?

https://www.hipaajournal.com/sue-for-hipaa-violation/

HIPAA VIOLATION

Former Executive Sentenced to Probation for HIPAA Violation

Mark Kevin Robison, a former vice president of Commonwealth Health Corporation (now Med Center Health) in Kentucky has been sentenced to 2 years' probation and ordered to pay $140,000 in restitution after reaching a plea agreement with federal prosecutors over a HIPAA violation.

Robison pled guilty to knowingly disclosing the protected health information of patients of Commonwealth Health Corporation (CHC) under false pretenses to an unauthorized third party between 2014 and 2015. Robison did not have authorization from the patients concerned nor from CHC to disclose the records.

While Vice President of CHC, Robison hired Randy Dobson as a patient account collection vendor for CHC. In March 2011, Robison and Dobson set up a corporation – OPTA LLC – in Kentucky. The pair were the only registered members and Robison was the registered agent. Dobson was developing a software solution and together the pair hoped to market the software to healthcare companies.

OPTA Kentucky was dissolved in 2014, and Delaware OPTA was incorporated the same year with Dobson listed as the sole owner. Delaware OPTA continued to develop the same software, and Robison hoped to share in the profits from the sale of the software when he left CHC. In 2014, Robison instructed the CHC IT department to share patient data with Dobson to test the software. The disclosures occurred between 2014 and 2015 without authorization from CHC or the patients concerned.

CHC learned of the relationship between Robison and Dobson, Robison was fired by CHC in December 2016, and the HIPAA violation was reported to law enforcement. Dobson is not believed to have disclosed the patient data to any other individuals and only used the data to test the software. While patients appear not to have suffered any harm, the potential penalty for the violation was severe.

Robison faced a maximum penalty of five years imprisonment and a fine of up to $100,000 for the HIPAA violation. Robison pled guilty to one count of impermissibly disclosing protected health information in a plea deal that saw him avoid jail and instead be placed on probation for 2 years. Robison was also ordered to pay CHC $140,000 in restitution. Half of that amount has already been paid and Robison intends to pay the remainder by the end of January

Read entire article:
https://www.hipaajournal.com/former-executive-probation-hipaa-violation/

ANTI-KICKBACK STATUE VIOLATION

Man Charged in $60M Health Care Fraud and Kickback Scheme

A federal grand jury in Miami returned an indictment charging a Texas man for his alleged role in a $60 million health care fraud, wire fraud, and kickback scheme involving the submission of false and fraudulent claims to Medicare for medically unnecessary durable medical equipment (DME), genetic tests, and foot bath medications. According to court documents, Robert Leon Smith III, 48, of Archer City, owned and/or operated a network of DME companies in Florida, Texas, and Maryland through which he allegedly billed Medicare for medically unnecessary orthotic braces that were ineligible for Medicare reimbursement.

Read entire article:
https://www.justice.gov/opa/pr/man-charged-60m-health-care-fraud-and-kickback-scheme

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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