COMPLIANCE CONNECTION

JULY 2022

This newsletter is prepared 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 Penalties 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 NEW Compliance Hotline
855-662-SAFE (7233)
Midland Health ID#: 6874433130
This ID# is required to submit a report.

MIDLAND HEALTH

COMPLIANCE TEAM

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DEPARTMENT OF JUSTICE NEWS

Woman Indicted for Prescribing Medically Unnecessary Medical Equipment in $8.8 Million Health Care Fraud Scheme

A Georgia woman was arrested yesterday in Hampton, Georgia, on criminal charges related to her alleged scheme to defraud Medicare by prescribing medically unnecessary durable medical equipment (DME), which was then billed to Medicare.

According to the indictment, Kateline Lavache, 53, of Hampton, allegedly prescribed medically unnecessary DME for Medicare beneficiaries in exchange for kickbacks and bribes from her co-conspirators. Lavache allegedly prescribed DME without conducting proper consultations with the beneficiaries. Lavache had no prior relationship with the beneficiaries, was not treating them, and failed to even conduct telemedicine consultations with them. As a result of the prescriptions, Lavache's co-conspirators submitted to Medicare approximately $8.8 million in false and fraudulent claims for medically unnecessary DME, of which Medicare paid more than $4 million. Lavache was paid more than $123,000 in kickbacks and bribes for her participation in the scheme.

Lavache is charged with one count of conspiracy to commit health care fraud and wire fraud, as well as four counts of health care fraud. If convicted, she faces up to 20 years in prison for the conspiracy count and up to 10 years in prison for each health care fraud count. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Assistant Attorney General Kenneth A. Polite, Jr. of the Justice Department's Criminal Division; U.S. Attorney Roger Handberg for the Middle District of Florida; Special Agent in Charge Omar Pérez Aybar of the Department of Health and Human Services, Office of the Inspector General (HHS-OIG), Miami Regional Office; and Assistant Director Luis Quesada of the FBI's Criminal Investigative Division; Special Agent in Charge David Walker of the FBI's Tampa Field Office made the announcement.

The FBI and HHS-OIG are investigating the case.

Trial Attorney Alejandro J. Salicrup of the Criminal Division's Fraud Section is prosecuting the case.
The Fraud Section leads the Criminal Division's efforts to combat health care fraud through the Health Care Fraud Strike Force Program. Since March 2007, this program, comprised of 15 strike forces operating in 24 federal districts, has charged more than 4,200 defendants who collectively have billed the Medicare program for more than $19 billion. In addition, the Centers for Medicare & Medicaid Services, working in conjunction with the Office of the Inspector General for the Department of Health and Human Services, are taking steps to hold providers accountable for their involvement in health care fraud schemes.

Resource:
https://www.justice.gov/opa/pr/woman-indicted-prescribing-medically-unnecessary-medical-equipment-88-million-health-care

DID YOU KNOW...

Office of Inspector General (OIG)

OIG's mission is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve.

Resource: https://oig.hhs.gov/about-oig/

MIDLAND HEALTH

MIDLAND HEALTH POLICYTECH

COMPLIANCE PROGRAM PLAN

PURPOSE

Midland County Hospital District d/b/a Midland Memorial Hospital is a Texas governmental entity, established under the Texas Constitution by the Texas Legislature, to provide medical care to the residents of its District. In pursuit of its legislative purpose, Midland Memorial Hospital supports and promotes charitable, educational and scientific purposes through the hospital as well as through its maintenance and support of its physician corporations and various corporate affiliations which support this mission. Midland Health (MH) is the entire system through which Midland Memorial Hospital conducts its activities in pursuit of its charitable, educational and scientific purposes.

MISSION Leading healthcare for greater Midland.

VISION Midland will be the healthiest community in Texas.

CORE VALUES:

Pioneer Spirit…

- We tell the truth and honor commitments.
- We innovate and embrace change.
- We are careful stewards of our resources.
- We overcome problems without complaining.
- We exceed quality and safety expectations through teamwork and partnerships.

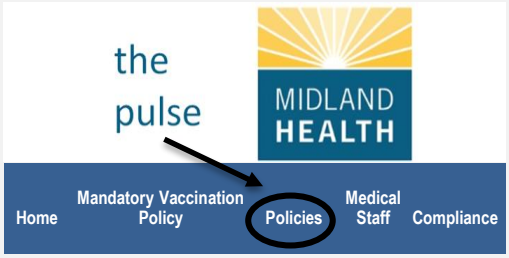
Healing Mission…

- We do our best to improve the health and well-being of our community.
- We are continuous learners.
- We create an environment that supports the healing process.
- We care for ourselves so we are able to care for others.
- We find joy in our work and have fun together.

Read entire Policy: Midland Health PolicyTech #8690 "Compliance Program Plan"

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

The Benefits of HIPAA Compliance for Medical Practices

https://www.hipaajournal.com/benefits-of-hipaa-compliance-for-medical-practices/

LINK 2

CISA Issues Emergency Directive to Patch Vulnerable VMWare Products

https://www.hipaajournal.com/cisa-issues-emergency-directive-to-patch-vulnerable-vmware-products/

LINK 3

Video: Why HIPAA Compliance is Important for Healthcare Professionals

https://www.hipaajournal.com/why-hipaa-compliance-is-important-for-healthcare-professionals/

LINK 4

Email Accounts Compromised at BJC HealthCare & Cooper University Health Care

https://www.hipaajournal.com/email-accounts-compromised-at-bjc-healthcare-cooper-university-health-care/

PHYSICIAN SELF-REFERRAL LAW *(STARK LAW)*

EXAMPLE OF STARK LAW VIOLATIONS

CITY OF ANGELS MEDICAL CENTER
TAKING ADVANTAGE OF THE HOMELESS

Allegations

- Medicare and Medi-Cal fraud scheme arising from their former ownership of the Los Angeles City of Angels Medical Center
  - – City of Angels paid "recruiters" employed at homeless shelters in the skid row area of the city to deliver their homeless clients by ambulance to the hospital for medical treatment regardless of whether their clients in fact needed or requested such treatment
  - – City of Angels would then bill the Medicare and Medi-Cal programs for a variety of medical services allegedly rendered to the homeless patients, many of which were not medically necessary

Final payout: $10,000,000.00

Resource: https://www.99mgmt.com/blog/stark-law-violation-examples

FALSE CLAIMS ACT (FCA)

Recent Kickback Cases Yield Almost $20 million in Settlements for the United States

athenahealth, Inc.
Agreed to Pay $18.25 Million to Resolve Allegations

On January 28, 2021, the DOJ announced a settlement with athenahealth, Inc. Under the settlement, athenahealth agreed to pay $18.25 million "to resolve allegations that it violated the False Claims Act (FCA) by paying illegal kickbacks to generate sales of its EHR [electronic health records] product athenaClinicals [and athenaOne]." According to the DOJ's complaint-in-intervention, athenahealth operated three marketing programs that paid kickbacks to customers in exchange for referring new clients to athenahealth. According to the complaint, one of the marketing programs involved invitations to existing and prospective customers for all-expense-paid sporting, entertainment and recreational events including trips to the Masters Golf Tournament, the Indy 500, New York Fashion Week and the Kentucky Derby with complimentary travel, luxury accommodations, meals and alcohol.

Another marketing program allegedly paid fees to its customers for "Client Lead Generation" in which athenahealth paid up to $3,000 per physician that signed up for athenahealth services, regardless of how much time the existing customer spent speaking or meeting with the prospective new customer. According to the United States' complaint, after another EHR vendor, eClinicalWorks, settled a lawsuit alleging violations of the FCA and Anti-Kickback Statute related to its referral program, athenahealth changed the name of its Client Lead Generation program to the "Introductions" program, but did not change the program substance and continued to pay existing clients for the volume and/or value of their referral of new customers. The third marketing program targeted competing EHR companies who were discontinuing their technology and offered "Conversion Deals," in which athenahealth paid competitors based on the volume and/or value of practices that were successfully converted into athenahealth customers.

Read entire article:
https://www.bricker.com/insights-resources/publications/recent-kickback-cases-yield-almost-20-million-in-settlements-for-the-united-states