JULY 2024

COMPLIANCE CONNECTION

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

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Midland Health PolicyTech: Policy #6541
Code of Conduct for Medical Staff and Practitioners *(See Page 2)*

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

COMPLIANCE TEAM

Michelle Pendergrass, MBA, CHC
Chief Compliance Officer/Privacy Officer
P: 432-221-1972
Michelle.Pendergrass@midlandhealth.org

Regenia Blackmon, *Compliance Auditor*
Regenia.Blackmon@midlandhealth.org

Melissa Sheley, *Sr. Compliance Analyst*
Melissa.Sheley@midlandhealth.org

California-Based Nursing Home Chain and Two Executives to Pay $7M to Settle Alleged False Claims for Nursing Home Residents Who Merely Had Been Near Other People With COVID-19

The United States and the State of California have reached a $7,084,000 civil settlement with ReNew Health Group LLC, ReNew Health Consulting Services LLC and two corporate executives for knowingly submitting false Medicare Part A claims for nursing home residents.

During the COVID-19 pandemic, in order to conserve hospital beds, the Centers for Medicare and Medicaid Services waived the requirement that a person must have had a hospital stay of at least three days (signaling an acute illness or injury) before reimbursing for skilled care in a nursing home. The United States and the State of California alleged that the defendants knowingly misused this waiver by routinely submitting claims for nursing home residents when they did not have COVID-19 or any other acute illness or injury, but merely had been near other people who had COVID-19. Under the settlement, the defendants will pay $6,841,727 to the United States and $242,273 to the State of California, plus interest.

"The Justice Department is committed to protecting the integrity of taxpayer-funded programs," said Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division. "We will hold accountable those who sought to defraud such programs during the COVID-19 pandemic, including those who knowingly misused emergency waivers for personal gain."

"False claims are anathema to the Medicare system, especially during a public health crisis," said U.S. Attorney Martin Estrada for the Central District of California. "This settlement agreement highlights my office's determination to ensure our nation's health care programs help those who actually need them."

This investigation was prompted by a lawsuit filed under the whistleblower provisions of the False Claims Act, which permit private parties to sue on behalf of the government to redress false claims for government funds and to receive a share of any recovery. The settlement agreement in this case provides for the whistleblower, Bay Area Whistleblower Partners, to receive $1,204,280, plus interest, as its share of the settlement.

Read entire article:
https://www.justice.gov/opa/pr/california-based-nursing-home-chain-and-two-executives-pay-7m-settle-alleged-false-claims

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

MIDLAND HEALTH • PT POLICYTECH® Policy & Procedure Management

CODE OF CONDUCT FOR MEDICAL STAFF AND PRACTIONERS

1.0 Purpose: This policy is to ensure that Midland Memorial Hospital is a safe and constructive workplace for everyone who is striving to provide the highest-quality patient care and to provide a method for reviewing and reporting events of physician behavior that are unexpected or in violation of the medical staff bylaws, regulations, and policies.

1.1 It is the expectation of the [Midland memorial Hospital] board of trustees that all members of the medical staff act in a professional and cooperative manner at the hospital, treating all patients and persons involved in their care with courtesy, dignity, and respect. These expectations are defined by the code of conduct.

1.2 Each member of the medical staff (individually, "physician") granted privileges at the hospital shall be required to acknowledge and agree to be bound by the code of conduct at the time of appointment/reappointment to promote and focus awareness of the essential elements of this policy.

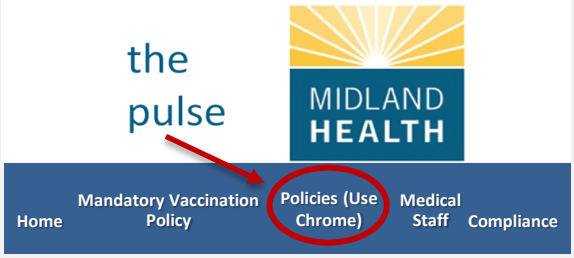
1.3 This policy sets forth procedures for reviewing and addressing behavioral incidents when a member of the medical staff conducts himself or herself in a manner that is inconsistent with this code of conduct.

2.0 DEFINITIONS: Disruptive or inappropriate behavior can be defined as an aberrant style of personal interaction between members of the healthcare team, patients, and/or their family members that interferes with the delivery of excellent patient care. The behavior could take the form of language, personal habits, or physical confrontation. The following is a list of examples and is not intended to be all-inclusive of disruptive or inappropriate behavior.

Read entire Policy:
Midland Health PolicyTech #6541 – "Code of Conduct for Medical Staff & Practitioners"

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
FTC Finalizes Settlement with Blackbaud and Orders Deletion of Personal Data
https://www.hipaajournal.com/ftc-finalizes-blackbaud-settlement/

LINK 2
New Jersey Nursing Facility to Pay $100,000 CMP to Resolve HIPAA Right of Access Violations
https://www.hipaajournal.com/new-jersey-nursing-facility-100000-cmp-hipaa-right-access/

LINK 3
HHS Issues Guidance to Teaching Hospitals and Medical Schools on Informed Consent Requirements
https://www.hipaajournal.com/hhs-guidance-teaching-hospitals-medical-schools-informed-consent/

LINK 4
What Information is Protected Under HIPAA Law?
https://www.hipaajournal.com/what-information-is-protected-under-hipaa-law/

FALSE CLAIMS ACT

Cape Cod Hospital to Pay $24.3 Million to Resolve False Claims Act Allegations Concerning Its Failure to Comply with Medicare Rules for Cardiac Procedures

Cape Cod Hospital, based in Hyannis, Massachusetts, has agreed to pay $24.3 million to resolve False Claims Act allegations that it knowingly submitted claims to Medicare for transcatheter aortic valve replacement (TAVR) procedures that failed to comply with Medicare rules specifying the way in which hospitals were required to evaluate patient suitability for the procedures.

Beginning in 2015, Cape Cod Hospital began offering TAVR procedures for patients suffering from aortic stenosis, a serious heart condition that restricts blood flow from the heart to rest of the body. A TAVR procedure involves replacing a patient's damaged heart valve with an artificial one. Medicare rules at the time required that, prior to performing a TAVR procedure, hospitals engage specified clinical personnel to conduct an independent examination of prospective patients to evaluate their suitability for TAVR, document the rationale for their clinical judgment and make the rationale available to the medical team performing the TAVR procedure. The settlement resolves allegations that from Nov. 1, 2015, through Dec. 31, 2022, Cape Cod Hospital knowingly submitted hundreds of claims to Medicare for TAVR procedures that did not comply with the applicable Medicare requirements. In some instances, not enough physicians examined a patient's suitability for the procedure, while in other instances the physicians failed to document and share their clinical judgment with the medical team responsible for the TAVR procedure.

"Hospitals that participate in the Medicare program must abide by applicable coverage and reimbursement rules," said Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division. "The department will hold healthcare providers accountable when they knowingly fail to comply with Medicare reimbursement requirements."

Read entire article:
https://www.justice.gov/opa/pr/cape-cod-hospital-pay-243-million-resolve-false-claims-act-allegations-concerning-its

MEDICARE FRAUD SCHEME

Doctor Convicted of $70M Medicare Fraud Scheme

A federal jury convicted a Texas doctor for causing the submission of over $70 million in fraudulent claims to Medicare for medically unnecessary orthotic braces and genetic tests ordered through a telemarketing scheme.

According to court documents and evidence presented at trial, David M. Young, M.D., 61, of Fredericksburg, signed thousands of medical records and prescriptions for orthotic braces and genetic tests that falsely represented that the braces and tests were medically necessary and that he diagnosed the beneficiaries, had a plan of care for them, and recommended that they receive certain additional treatment. Young prescribed braces and genetic tests for over 13,000 Medicare beneficiaries, including undercover agents posing as different Medicare beneficiaries, many of whom he did not see, speak to, or otherwise treat. Young's false prescriptions were then used by brace supply companies and laboratories to bill Medicare more than $70 million. Young was paid approximately $475,000 in exchange for signing the fraudulent prescriptions.

The jury convicted Young of one count of conspiracy to commit health care fraud, which carries a maximum penalty of 10 years in prison, and three counts of false statements relating to health care matters, each of which carries a maximum penalty of five years in prison. He is scheduled to be sentenced at a later date. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Read entire article:
https://www.justice.gov/opa/pr/doctor-convicted-70m-medicare-fraud-scheme

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

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

Regenia Blackmon
Compliance Auditor
Regenia.Blackmon@midlandhealth.org