COMPLIANCE CONNECTION

SEPTEMBER 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

Jury Convicts Man of $600 Million Health Care Fraud, Wire Fraud, and ID Theft Scheme

The A federal jury convicted a New York man today in an over $600 million health care fraud, wire fraud, and identity theft scheme.

According to court documents and evidence presented at trial, Mathew James, 54, of East Northport, operated a medical billing company that billed for procedures that were either more serious or entirely different than those James' doctor-clients performed. James directed his doctor-clients to schedule elective surgeries through the emergency room so that insurance companies would reimburse at substantially higher rates. When insurance companies denied the inflated claims, James impersonated patients to demand that the insurance companies pay the outstanding balances of tens or hundreds of thousands of dollars.

"James orchestrated a fraudulent medical billing scheme to steal from insurance companies and businesses, in order to line his own pockets," said Assistant Attorney General Kenneth A. Polite, Jr. of the Justice Department's Criminal Division. "This conviction shows that medical billers who fuel health care fraud will be brought to justice."

"The defendant stands convicted of carrying out an audacious scheme in which he used insurance companies like ATM machines. He stole hundreds of millions of dollars until he was finally exposed by a paper trail a mile-long, phone recordings on which he impersonated patients, and text messages and emails with his co-conspirator doctor clients demonstrating his nefarious billing practices. For this massive fraud, a federal jury convicted him today," said U.S. Attorney Breon Peace for the Eastern District of New York. "Health care fraud is not a victimless crime, because fraudulent billing ultimately affects consumers who must pay the cost of higher insurance premiums."

"Health care fraud, including fraudulent billing schemes like this, costs U.S. taxpayers tens of billions of dollars annually. These crimes impact all of us in many ways, including increased health insurance premiums, greater out-of-pocket expenses and copayment amounts for medical treatment, and reduced or lost benefits, just to name a few," said Assistant Director Luis Quesada of the FBI's Criminal Investigative Division. "The FBI, together with our law enforcement partners, is committed to rooting out health care fraud in all its forms and bringing those who seek to exploit our health care system to justice."

James was convicted of conspiracy to commit health care fraud, health care fraud, three counts of wire fraud, and three counts of aggravated identity theft. He is scheduled to be sentenced at a later date and faces up to 10 years in prison for health care fraud conspiracy, up to 10 years in prison for health care fraud, up to 20 years in prison for each of three wire fraud counts, and a two year mandatory minimum each for three aggravated identity theft counts.

Resource:
https://www.justice.gov/opa/pr/jury-convicts-man-600-million-health-care-fraud-wire-fraud-and-id-theft-scheme

DID YOU KNOW...

OFFICES OF THE UNITED STATES ATTORNEYS

The President appoints a United States Attorney to each of the 94 federal districts (Guam and the Northern Mariana Islands are separate districts but share a United States Attorney). The United States Attorney is the chief federal law enforcement officer in their district and is also involved in civil litigation where the United States is a party.

Resource: https://www.justice.gov/usao

MIDLAND HEALTH

MIDLAND HEALTH POLICYTECH

Destruction of Protected Health Information

POLICY

Purpose: This policy will establish guidelines for appropriate destruction of protected health information.

Policy:

I. Destruction of patient health information shall be carried out in accordance with federal and state laws, and pursuant to a written retention schedule and destruction policy approved by the Director of HIM (Health Information Management/Medical Records), Chief Executive Officer, Medical Staff and Midland Memorial Hospital legal counsel.

II. The following retention schedule will be used to determine when medical records may be destroyed:
   a. If the patient is 18 years of age or older on the day of treatment, the record for that specific treatment may be destroyed 10 years later.
   b. If the patient is under 18 years of age on the day of treatment, the record for that specific treatment may be destroyed on or after the patient's 20th birthday or on or after the 10th anniversary of the date on which the patient was last treated, whichever date is later.

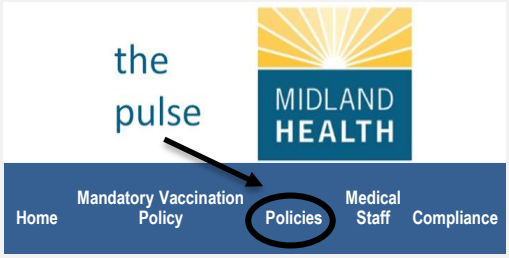
Procedure:

I. The Director of HIM or designee will:
   a. Consult the above retention schedule to make sure the required retention period has been fulfilled.
   b. Contact Quality Management to ensure that the record is not subject to pending litigation.
   c. Ensure that the records are destroyed in a manner wherein there is no possibility of information reconstruction.
   d. Ensure that information on back-up media has also been destroyed.
   e. Ensure that the appropriate method of destruction is used:
      i. Paper media – Shredding, pulping or burning
      ii. Microfilm or microfiche – Shredding
      iii. CD-ROM, CD-RW or DVD - Shredding or physically destroying the disk.

Read entire Policy: Midland Health PolicyTech #88 "Destruction of Protected Health Information"

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

Survey Reveals Bad Cyber Hygiene and Poor Password Practices are Commonplace

https://www.hipaajournal.com/survey-reveals-bad-cyber-hygiene-and-poor-password-practices-are-commonplace/

LINK 2

OCR Announces 11 Further Financial Penalties for HIPAA Right of Access Failures

https://www.hipaajournal.com/ocr-announces-11-further-financial-penalties-for-hipaa-right-of-access-failures/

LINK 3

Dental Care Alliance Settles Class Action Data Breach Lawsuit for $3 Million

https://www.hipaajournal.com/dental-care-alliance-settles-class-action-data-breach-lawsuit-for-3-million/

LINK 4

Department of Justice Announces Seizure of $500,000 in Ransom Payments Made by U.S. Healthcare Providers

https://www.hipaajournal.com/department-of-justice-announces-seizure-of-500000-in-ransom-payments-made-by-u-s-healthcare-providers/

PHYSICIAN SELF-REFERRAL LAW *(STARK LAW)*

EXAMPLE OF STARK LAW VIOLATIONS

VANGUARD HEALTH SYSTEMS - IMPROPER SUPERVISION

Allegations

- Knowingly paying certain physicians salaries and bonuses that were above fair market value and in violation of the Stark Law and the Anti-Kickback Statute
  - Upcoding Medicare billings for E&M patient visits in order to obtain larger payments than allowable for the services actually provided
  - Billing for cardiac rehabilitation therapy provided by a physician who was not properly supervising the therapists providing the services

Final payout: $2,900,000.00

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

FALSE CLAIMS ACT (FCA)

TEXAS DOCTOR ACCUSED OF FALSE CLAIMS ACT VIOLATIONS

The United States Attorney's Office for the Northern District of Texas has filed a False Claims Act lawsuit against a Texas dermatopathologist and his clinic, Cockerell Dermatopathology (CDP), for submitting nearly $4.2 million in fraudulent claims to TRICARE, announced Acting U.S. Attorney Prerak Shah.

According to allegations in a civil complaint filed Monday, Dr. Clay Cockerell, 64, knowingly permitted a laboratory management company to use his clinic's lab license to submit false claims to federal health insurance programs, including TRICARE, for medically unnecessary tests.

The complaint alleges that in March 2015, Dr. Cockerell signed an agreement that authorized the management company, Progen, to use CDP's CLIA lab license to submit claims for payment for toxicology and pharmacogenomic tests. In return, Progen agreed to pay CDP twenty percent of the net revenue from those tests.

In an attempt to avoid the reach of the federal Anti-Kickback Statue (AKS), Dr. Cockerell specified that CDP would not provide any testing services to beneficiaries of federal health insurance programs, such as TRICARE, Medicare, or Medicaid, or collect any federal revenue.

According to the complaint, Dr. Cockerell quickly became aware that Progen was violating their agreement and submitting claims to federal healthcare programs. He also learned that Progen was engaged in gross mismanagement and abusive practices, and even received warnings that CDP was violating the False Claims Act.

Meanwhile, Progen marketers were offering $50 Wal-Mart gift cards to induce TRICARE beneficiaries to provide urine and saliva for expensive, medically unnecessary testing.

Despite these and other red flags, the complaint alleges that Dr. Cockerell continued to permit Progen, using CDP's license, to submit fraudulent claims to TRICARE.

Read entire article:
https://www.justice.gov/usao-ndtx/pr/texas-doctor-accused-false-claims-act-violations