

TRENDS IN COMPLIANCE: AVOIDING POTENTIAL FRAUD AND ABUSE VIOLATIONS

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Today's healthcare professionals face a myriad of legal and compliance issues in the provision of their trades. The 1980s were witness to much of the development of our current malpractice environment. Professionals in the 1990s and beyond have become aware and must continue to adapt to a new threat on the healthcare landscape: Medicare and Medicaid fraud and abuse. Institutional providers have responded to this threat, in part, by employing compliance officers and conducting internal audits. Physicians have examined their patient referral practices to ensure that they are in compliance with the fraud and abuse provisions. Similarly, dentists and orthodontists must adapt their practices and be aware of potential violations that carry significant financial and professional costs.

The Fraud and Abuse Statutes

Various federal statutes may serve individually or collectively to penalize providers who violated the Medicare and Medicaid fraud and abuse provisions. Criminally, making false statements or representations when seeking reimbursement from a federal health program may result in a fine up to \$25,000, five years imprisonment or both. Administrative actions may be brought under the Civil Monetary Penalties statute or the Exclusion statute. The Civil Monetary Penalties provision may penalize providers up to \$10,000 for each item or service falsely claimed, an additional financial penalty up to three times the amount claimed and possible exclusion from the federal and state health programs. The Exclusion statute provides for mandatory exclusion from the federal health programs for a period of five years for felony convictions relating to claims under the health programs or a minimum exclusion for three years for misdemeanor convictions (at the Secretary of Health and Human Services' discretion).

Dentists and orthodontists may also face liability in civil court under the False Claims Act (FCA). The FCA allows private, or qui tam, plaintiffs to bring suit against government contractors, such as Medicare and Medicaid providers, on behalf of the federal government. These claims have become increasingly common in healthcare in recent years as plaintiffs look to recover a portion of damages of between \$5,000 to \$10,000 per false claim and three times the damage sustained by the government. FCA actions are expected to rise

considerably in the future. In February of 1999 the American Association of Retired Persons and the U.S. Department of Health and Human Services joined forces to launch the "Who Pays? You Pay" campaign to ensure that Medicare beneficiaries are trained to recognize fraudulent conduct. Hundreds of thousands of beneficiaries are expected to be trained in 1999 alone.

Compliance Issues for Employed Professionals

Increasingly, dentists and orthodontists are selling their practices and entering into employment relationships. Part of this trend is due to the growing legal and operational complexities of remaining an independent practitioner. Faced with spending a large percentage of their time consumed by paperwork and office administration, many healthcare professionals have sold their practices and sought employment expecting their employers to be responsible for handling the administrative tasks.

Employment does offer a dentist or orthodontist more time to engage in professional activities. However, the fact that an employer is expected to do the billing to federal and state health programs does not relieve the professional from responsibility to ensure adherence to the fraud and abuse provisions. In fact, an employment relationship offers new and different compliance issues which a practitioner may not expect.

An employed professional must ensure that his or her services are accurately reported to the employer as they are performed. Employers rely on these reports to bill Medicare, Medicaid and other third party payors and when awarding bonus compensation to employees based on productivity. Employed professionals must be very careful when completing time and services logs. Carelessness or dishonesty when completing them could result in criminal and civil penalties as well as exclusion from participation in Medicare and Medicaid. These penalties could occur despite the fact that the professional did not know that the patient he or she was seeing was a beneficiary of the federal health programs.

Under the Exclusion statute, providers may be excluded from participating in the federal health programs if they are convicted of a felony or misdemeanor that is "program-related." Department Appeals Boards have held that a "program-related" conviction is one where there is a logical nexus or common sense connection between the offense for which the individual has been convicted and the Medicare or Medicaid programs. Such a logical nexus has been found by Department Appeals Boards when employed professionals have submitted false activity logs to their employers- even without the realization a Medicare or Medicaid patient had been treated and even though only the employer has authority to seek reimbursement. Because the employers submit these services to the federal health programs for reimbursement, the professional is found to have violated the fraud and abuse provisions and is subject to penalties.

Employed and independent professionals alike must also closely monitor their time with each patient and be wary of endorsing activity reports prepared by others. Losing track of time and services devoted to patients may result in the appearance of wrongdoing and penalties. One dentist's corporation treated a large volume of mobile dental services to nursing home patients. His services were provided predominantly to Medicaid patients and consisted of examinations and prophylaxis. Upon the investigation by a state agency, it was found that the dentist spent less than 4 minutes with each Medicaid recipient and it was determined that the services he sought reimbursement for could not be provided in that time period. Providers must carefully complete time and service sheets to avoid the appearance of impropriety. Otherwise, they may be the subject of scrutiny when services are actually delivered.

Finally, employed dental practitioners must not endorse submissions to health programs without scrutinizing what services are being claimed. A professional should not assume that he or she should sign whatever they are asked because it is only the employer who is authorized to seek reimbursement. Under the Civil Monetary Penalties statute, the dentist or orthodontist may be found liable for penalties when they "should know" they are submitting false or fraudulent claims but act with reckless disregard or deliberate ignorance of a claim's truth or falsity.

Obtaining Patient Referrals

Like most health professionals, dentists and orthodontists rely on each other and other health providers for patient referrals. However, the manner in which these referrals are obtained may give rise to compliance issues. The civil and criminal provisions of the Anti-kickback statute prohibit the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for or to induce the referral of any patient for any service that may be paid by federal health programs. Providers must be very conscious of any benefit that is exchanged with another provider who is the source of referrals regardless of whether the perceived benefit conferred is of little or non-monetary value.

The Anti-kickback provisions are very broad and have resulted in varying judicial opinions of their application. One practitioner was found in violation merely for admitting that just one reason he referred patients to sources was the hope of inducing return referrals from those sources in the future. The U.S. Court of Appeal for the Third Circuit found that the statute was violated by having the intent to induce future referrals as just one consideration when providing remuneration. It was never determined or even alleged that the referrals were for unnecessary services or resulted in monetary loss to the government. The Anti-kickback statute requires dentists and orthodontists to carefully consider their referral practices and whether any benefit is conferred upon them or others as a result of referrals.

The Status of Student Loan Payments

Another legal trend evolving into a compliance issue involves the failure to repay Health Education Assistance Loans (HEALs). Failure to repay HEALs may result in exclusion from the Medicare and Medicaid programs. The Secretary of HHS has the authority to exclude a party from participating in Medicare or Medicaid who “is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to secure repayment of such obligations or loans...”

The Secretary of HHS has been actively seeking repayment of loans from healthcare providers. However, before excluding them, the Secretary must take “all reasonable steps” to obtain payment. These steps typically include repeated notice, approved delays in repayment, and offers to allow garnishment of amounts owed under the federal health programs. Providers must not ignore the demands for repayment. Those who do may face exclusion and the reality that repaying significant HEALs amounts is even more difficult to do when excluded from Medicare and Medicaid participation.

What if You Are Accused of Criminal Wrongdoing?

A dental professional may be charged with criminal wrongdoing regarding claims or services involving the Medicare or Medicaid programs. In one such instance, the charge against a dentist involved unlawfully soliciting money from a patient’s aunt when he was required by contract and state regulations to accept payment from Medicaid as his sole payment. Noting that the time, expense and risks of a state trial would probably be worse than the punishment for the alleged offense, the dentist entered an “Alford” plea in which he pled guilty but maintained his innocence and stated his plea was to avoid the waste of time and expense of a trial. As a result of the plea, the dentist paid restitution of \$1,200, performed community service, paid the court \$15 and the victim \$75. Three months later, at his request, the court withdrew his guilty plea, ordered the conviction vacated and dismissed the action.

The dentist was subsequently excluded from participation in Medicare and Medicaid for five years. A state court’s acceptance of an “Alford” or no contest plea is regarded as a criminal conviction under the administrative Exclusion Statute. Therefore, a mandatory exclusion of at least five years is given for felony convictions. The court’s later willingness to expunge the dentist’s record was also not effective in protecting the dentist from culpability. Post pleading erasures of convictions are included within the statutory definition of conviction. Therefore, providers, when charged with a crime, must weigh the consequences of possible exclusion with the convenience of making a plea and paying a fine.

Conclusion

The compliance trends discussed above are by no means exclusive of what dentists, orthodontists or other health providers must be aware. The issues discussed are merely to illustrate the need to be aware of some potential fraud and abuse violations so they may be prevented or addressed promptly and correctly. All healthcare providers should endeavor to prepare for ever more vigilant government action taken in regard to fraud and abuse violations.

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