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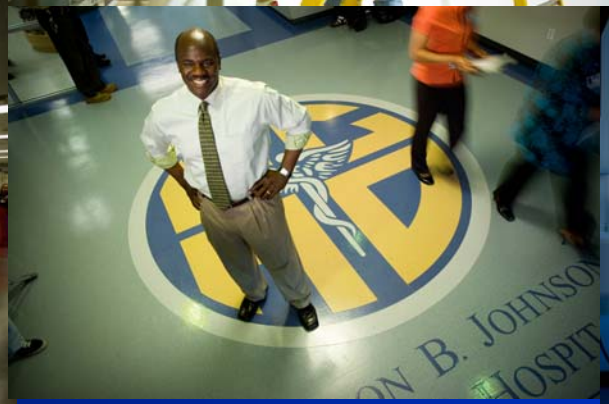
ADVANCED COMPLIANCE TRAINING 2011





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Introduction

This self-guided advanced training will provide you with additional education on the following subjects (a-g):

a. Federal Health care program requirements regarding accurate coding and submission of claims;

b. Policies, procedures and other requirements applicable to the documentation of medical records;

c. The personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

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Introduction (continued)

d. Applicable reimbursement statutes, regulations, and program requirements and directives;

e. The legal sanctions for violations of Federal health care program requirements;

f. Examples of proper and improper claims submission practices; and

g. Proper procedures for processing Medicare secondary payer claims.

Introduction (continued)

- The training has been broken into two Modules (or sections) for ease of use. The first covers Healthcare Programs and the second covers Claims, Fraud & Abuse and Obligations.
- Users may review the slides online as many times as needed.
- There is a comprehensive test (covering both modules) at the end. The test with a passing score of 80% is required for certain employees and individuals, for example employees involved in billing and coding or provision of patient items and services. The test can be taken as many times as needed to achieve a passing score.

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Topics

In order to provide you with additional education on subjects (a) – (g), the following topics will be covered:

MODULE I

- Healthcare Programs

MODULE II

- Claims;
- Fraud and Abuse; and
- Obligations.

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MODULE I
HEALTHCARE PROGRAMS

Healthcare Programs

Healthcare Programs consist of:

- Federal Healthcare Programs;
- State Healthcare Programs; and
- Other Healthcare Programs.

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Healthcare Programs

Federal Healthcare Programs include:

- Medicare;
- Black Lung;
- TRICARE;
- Veterans Affairs; and
- Federal Employees Health Benefit Plan.

Healthcare Programs - Medicare

- Federally funded program under which people over 65 years or with certain disabilities may obtain health care coverage.
- Supported by the Social Security Administration and Railroad Retirement Board benefits (Medicare card may show either).

Healthcare Programs - Medicare

- Part A – Hospital Insurance (inpatient)
- Part B – Medical Insurance
  (professional services/outpatient)
- Part C – Medicare Advantage
  (Managed Care)
- Part D – Prescription Drugs

Healthcare Programs - Medicare

- Medicare – Part A (Hospital Insurance):
  - Provides hospital insurance coverage;
  - Payment is generally made under the Prospective Payment System; and
  - Financed through payroll taxes and self-employed individual contributions.

Healthcare Programs - Medicare

- Medicare Part A Benefits include:
  - Inpatient hospital services;
  - Skilled nursing services;
  - Home health services; and
  - Hospice services.

Healthcare Programs - Medicare

Benefit Periods – Medicare Part A

- Basic or Full Days:
  - The first 60 days of acute inpatient care provided to a Medicare beneficiary; and
  - The beneficiary's financial responsibility is limited to the deductible for the benefit period.

Healthcare Programs - Medicare

Benefit Periods

- A benefit period is a period of time during which medical benefits are available to an insured beneficiary.
- Medicare Part A – a benefit period:
  - Starts the day a patient enters the hospital or skilled nursing facility (SNF) if the patient has not been an inpatient or SNF patient in the last 60 days; and
  - Ends when the patient has not been an inpatient or SNF patient for 60 consecutive days.

Healthcare Programs - Medicare

Benefit Periods – Medicare Part A

- Co-Insurance Days:
  - The 61st – 90th day of acute inpatient care provided to a beneficiary during a benefit period; and
  - The beneficiary is financially responsible for the benefit period deductible and an additional amount of $248 per day.

Healthcare Programs - Medicare

Benefit Periods – Medicare Part A

- Lifetime Reserve Days:
  - The 91st-150th day of acute inpatient care provided to a beneficiary during a benefit period;
  - The beneficiary is financially responsible for $496 per day for each day used; and
  - These benefits must be elected by the beneficiary and can never be reused or replaced.

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Healthcare Programs - Medicare

Skilled Nursing Days – Medicare Part A:

- 100% coverage for the first 20 days of the benefit period;
- The 21st-100th day of skilled nursing care is subject to the co-insurance amount of $124.00 per day;
- Skilled nursing benefits exhaust on the 101st day of skilled care; and
- The benefit period renews 60 days after the last inpatient or skilled care admission.

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Healthcare Programs - Medicare

Requirements for Skilled Nursing Facilities (SNF) Benefits under Medicare Part A:

- To receive SNF benefits, the beneficiary must have a 3 consecutive day acute care admission during the prior 30-day period, and observation days do not qualify; and
- Failure to meet this requirement means that no benefits are payable for the SNF stay.

Healthcare Programs - Medicare

- Medicare – Part B (Medical Insurance):
  - Provides medical insurance coverage for outpatient and professional services;
  - Payment is generally made pursuant to a fee schedule; and
  - Financed through premium payments by enrollees, contributions from general revenues by the federal government, and interest earned on the Part B trust fund.

Healthcare Programs - Medicare

- Medicare Part B Benefits include:
  - Outpatient hospital services;
  - Professional services;
  - Durable Medical Equipment (DME) and its required supplies (HCHD is not a DME provider);
  - Ambulance services; and
  - Clinical and diagnostic laboratories.

Healthcare Programs - Medicare

Services NOT Covered:

- Convenience items;
- Cosmetic surgery (except after accident);
- Custodial care; and
- Dental, routine foot care and orthopedic shoes (except for diabetes).

Healthcare Programs - Medicare

Services ALSO NOT Covered:

- First 3 pints of blood (unless someone donates in your name);
- Private-duty nurses;
- Routine physical exams, eye exams, glasses, contact lenses (except after cataract surgery), hearing aids; and
- Self-administrable medications (unless used in DME).

Healthcare Programs - Medicare

- Medicare – Part C (Medicare Advantage):
  - Beneficiaries receive traditional Medicare covered services through enrollment in a managed care organization;
  - Coverage also includes wellness and preventative programs; and
  - Financed through Medicare Parts A and B.

Healthcare Programs - Medicare

- Medicare – Part D (Prescription Drugs):
  - Administered by private Prescription Drug Plans; and
  - Financed by premiums paid by Medicare beneficiaries.

Healthcare Programs – Black Lung

- The Black Lung Benefits Act (BLBA) provides monthly payments and medical benefits to coal miners totally disabled from pneumoconiosis (black lung disease) arising from employment in or around the nation's coal mines.
- If the diagnosis on the claim is related to Black Lung Disease, then primary responsibility belongs to The Department of Labor, under the Black Lung Program.

Healthcare Programs - TRICARE

- TRICARE DOD (formally CHAMPUS) is the military health care program serving active duty service members, retirees, their families, survivors and certain former spouses worldwide.
- Eligibility for TRICARE is determined by the uniformed services and reported to the Defense Enrollment Eligibility Reporting System (DEERS).
- In general, active duty and retired service members of the uniformed services, and their families, are eligible for TRICARE.

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Healthcare Programs – Veterans Affairs

- Veterans Affairs (VA) provides a standard enhanced health benefits plan, called the Medical Benefits Package, to all enrolled veterans.
- Generally, services provided under this benefits plan are provided at a VA facility.

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Healthcare Programs - FEP

- The Federal Employees Health Benefit Plan provides health benefits to full-time permanent civilian employees of the United States Government.

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Healthcare Programs

State Healthcare Programs Include:

- Medicaid;
- Workers' Compensation;
- Crime Victims' Compensation;
- Employees Retirement System of Texas (ERS) - State Employees; and
- County Indigent Healthcare Program.

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Healthcare Programs – Medicaid

- A jointly funded state-federal needs based health care program.
- Established in Texas in 1967.
- Administered by the Health and Human Services Commission.

Healthcare Programs – Medicaid

Covered Services include:

- Acute health care:
  - Physician, inpatient, outpatient, pharmacy, lab, and X-ray.
- Long term services and support for aged and disabled persons.
- Preventative care.

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Healthcare Programs – Medicaid

Eligible persons:

- Low-income families;
- Non-disabled children;
- Related caretakers of dependent children;
- Pregnant women;
- Elderly; and
- People with disabilities.

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Healthcare Programs – Medicaid

Federally mandated benefits to be covered by Medicaid include:

- Inpatient and outpatient hospital care;
- Home health care;
- Lab and x-ray;
- Nursing facility care; and
- Early periodic screening, diagnosis, and treatment (also known as Texas Health Steps.)

Healthcare Programs - Medicaid

Federally mandated benefits to also be covered by Medicaid also include:

- Pregnancy related services;
- Family planning/genetics;
- Certified Nurse Midwife; and
- Certified Pediatric and Family Nurse Practitioner.

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Healthcare Programs – Medicaid

In addition, Texas has decided to cover some optional services under Medicaid, such as:

- Psychology;
- Speech therapy;
- Physical therapy; and
- In Home Respiratory care.

Healthcare Programs – Medicaid

Prescription Drugs

- The Texas Medicaid program covers most outpatient prescription drugs through the Vendor Drug Program (VDP). There is a monthly limit of three (3) prescriptions.
- As of January 1, 2006, clients who are dually eligible for Medicaid and Medicare will receive most of their prescription drugs through Medicare Part D.

Healthcare Programs - Medicaid

Limits on Texas Medicaid services include:

- A 30-day annual limit on inpatient hospital stays per spell of illness. More than one 30-day hospital visit can be paid for in a year, if the stays are separated by 60 or more consecutive days;
- Three outpatient drug prescriptions per month for some Medicaid patients; and
- Exception – the limits do not apply to children under 21 if there is a medical necessity for additional services.

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Healthcare Programs – Workers' Compensation

- State-regulated insurance program that pays an individual's medical bills if:
  - The individual is injured at work or has a work-related illness; and
  - The individual's employer has workers' compensation insurance under the Texas Workers' Compensation Act.
- For more information contact (800) 252-7031.

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Healthcare Programs – Crime Victims' Compensation

- State-regulated program that may pay a crime victim's medical bills if the crime:
  - Occurred in Texas to a Texas or U.S. resident, OR
  - Involved a Texas resident who became a victim in another state or country that does not have crime victims' compensation benefits for which the victim is eligible.
- Administered by the Attorney General of Texas and funded by court costs collected by Texas Courts from convicted offenders.

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Healthcare Programs – Crime Victims' Compensation

The following individuals may qualify for Texas Crime Victims' Compensation:

- An innocent victim of crime who suffers physical and/or emotional harm or death;
- An authorized individual acting on behalf of a victim; and
- A person who legally assumes the obligations or voluntarily pays certain expenses related to the crime on behalf of the victim.

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Healthcare Programs – Crime Victims' Compensation

The following individuals may also qualify for Texas Crime Victims' Compensation:

- A dependent of the victim;
- An immediate family member or household member related by blood or marriage who requires psychiatric care or counseling as a result of the crime;
- An intervener who goes to the aid of the victim or a peace officer; and
- A peace officer, fire fighter, or individual whose employment includes the duty of protecting the public.

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Healthcare Programs – Crime Victims' Compensation

Compensation may be awarded to victims of crimes involving:

- "criminally injurious conduct," which is defined as conduct that occurs or is attempted, poses a substantial threat of personal injury or death and is, or would be, punishable by fine, imprisonment or death.

Healthcare Programs – Crime Victims' Compensation

Examples of applicable crimes:

- Sex offenses;
- Kidnapping;
- Aggravated robbery;
- Assault offenses;
- Arson;
- Homicide; AND
- Other violent crimes where the victim suffers physical or emotional harm or death.

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Healthcare Programs – Crime Victims' Compensation

The following motor-vehicle related crimes are also covered:

- Failure to stop and render aid;
- DWI;
- Manslaughter;
- Criminally Negligent Homicide;
- Aggravated Assault;
- Intoxication Manslaughter; and
- Intoxication Assault.

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Healthcare Programs – Crime Victims' Compensation

- Claims under Texas Crime Victims' Compensation may be approved for benefits up to a total of $50,000, which may be paid to the victim/claimant or to service providers on behalf of the victim for certain expenses related to the crime.
- In addition, in the case of catastrophic injuries resulting in a total and permanent disability, the victim may be eligible for $75,000 in additional benefits for other specific expenses related to the crime.

Healthcare Programs – Crime Victims' Compensation

- The Crime Victims' Compensation Fund is a payer of last resort, meaning that all other available resources have to pay before any payment by the Crime Victims' Compensation Fund will be made.
- For more information please contact the Crime Victims' Compensation Program at (800) 983-9933.

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Healthcare Programs - ERS

- In 1947, the Texas Legislature created the Employees Retirement System of Texas (ERS) to serve the employees and retirees of the state of Texas.
- ERS started with retirement benefits, but their role has grown over the years and today includes the administration of health insurance benefits for employees and retirees of the state of Texas, as well as their dependents.
- For more information contact (800) 275-4377.

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Healthcare Programs – Indigent Care

- Title 25, Part 1, Chapter 14 of the Texas Administrative Code established the County Indigent Health Care Program, which provides health care services to eligible residents through the counties, hospital districts and public hospitals in Texas.
- Under this program, counties are required to provide Basic Health Care Services to eligible residents and may elect to provide a number of DSHS-established Optional Health Care Services.
- Administered by the Texas Department of State Health Services.
- For more information contact (512) 458-7706.

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Healthcare Programs - Indigent Care

- Harris County residents are eligible for indigent benefits for HCHD hospital and medical care (included in the HCHD Schedule of Benefits) based upon their ability to pay.
  - Indigent – Harris County residents who fall at or below 100% of federal poverty guidelines based on gross family income and family size.
  - Needy – Harris County residents who fall between 100% and 250% of federal poverty guidelines based on gross family income and family size.

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Healthcare Programs - Other

- Commercial Health Plans
  - The individual pays all or a portion of the healthcare for themselves and their dependents (e.g., Aetna, United Healthcare.)
- Employer or Group Health Plans
  - The employer or group (e.g., Union) pays all or a portion of its employees' and possibly its employees' dependents' healthcare.

Determining Eligibility for Benefits

In order to determine if someone has been deemed eligible for benefits, the following should take place:

- Medicare – Presentation of Medicare Card (online verification with FSS);
- Medicaid – Presentation of Medicaid Card or Form (online verification with TMHP);
- Check for other 3rd Party Liability; and
- HCHD Charity – Presentation of Gold Card (HCHD is the benefit of last resort).

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Coordination of Benefits

The coordination of benefits involves identifying who has:

- Primary Responsibility;
  - Insurance with primary (highest) responsibility to reimburse for covered expenses.
- Secondary Responsibility;
  - Insurance with secondary (second highest) responsibility to reimburse for covered expenses.
- Subrogation Rights;
  - Insurance which assumes the legal rights of an individual for whom covered expenses have been paid.

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MODULE II

CLAIMS
FRAUD AND ABUSE
OBLIGATIONS

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CLAIMS

Claims

- The topics for claims consists of:
  - Medicare Secondary Payor (MSP) Questionnaire;
  - Charging;
  - Medical Necessity/ABN;
  - Documentation;
  - Coding;
  - Billing; and
  - Claims Submission.

Claims - MSP

- Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first.

Claims - MSP

- Medicare is generally the secondary payer when one of the following exists:
  - Working aged individuals;
  - Disabled individuals;
  - Individuals with End Stage Renal Disease (ESRD);
  - Automobile or No-Fault Coverage present;
  - Liability occurred;
  - Individuals with Black Lung; and
  - Worker's Compensation Coverage present.

Claims – MSP Questionnaire

- Medicare MSP Requirements:
  - Providers are required to determine whether Medicare is the primary or secondary payer for each inpatient admission and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare; and
  - Determination of liability is established based on information provided by the patient or the patient's representative through the MSP Questionnaire.

Claims – Charging

- Charges should be identified and posted to a patient's account at the time of service based on the written documentation supported in the medical record.

Claims - Charging

- Providers shall not bill for the comprehensive code and the component parts of that code.
- Billing for a comprehensive code and the component codes is considered billing for unbundled charges.

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Claims – Charging

- Codes representing mutually exclusive services cannot be submitted together. These codes by definition cannot reasonably be performed at the same session or by the same provider on the same patient.

Claims – Charging

- There may be circumstances when codes pairs, which are not normally billed together, are allowable if a modifier is present on the charge.
- For example, two separately identifiable and distinct clinic visits on the same day. Determination of modifier use should be supported by a review of the medical record documentation.

Claims - Charging

- If the documentation supports the fact that this is a separate encounter or procedure, then the appropriate modifier should be appended to the charge and submitted with the claim.
- If no supporting documentation is available in the chart, the code and charge need to be removed from the patients account and claim.

Claims - Medical Necessity/ABN

- CMS definition – reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Generally, accepted standards of medical practice in the state are used as the basis for these determinations of medically necessary services.
- If the services are not medically necessary an Advanced Beneficiary Notice (ABN) must be completed and signed by the patient.

Claims - Medical Necessity/ABN

- Medically necessary services must be:
  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate in terms of type, frequency, extent, site and duration;
  - Not for the convenience of the patient, physician, or other health care provider; and
  - Performed or prescribed by the physician.

Claims – Medical Necessity/ABN

- Medicare patients must sign an ABN form if the medical treatment ordered does not meet Medicare's medical necessity guidelines.
- By signing the form and receiving the non-covered treatment, the patient becomes responsible for the charges related to the treatment, and payment should be collected at the time of service.
- Without a completed ABN, the facility is not able to bill the beneficiary or Medicare for charges that do not meet medical necessity.

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Claims – Medical Necessity/ABN

- Required Components:
  - Date of notice/service;
  - Clearly identified item or service;
  - Statement that the provider believes Medicare is likely or certain to deny payment for the particular item or service;
  - Explanation of reason for denial in simple layman's terms;
  - Notice of right to bill; and
  - Signature of beneficiary, or the beneficiary's personal representative.

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Claims - Documentation

- General Documentation Requirements:
  - Legible;
  - Provided services documentation supports medical necessity, billing and coding;
  - History and physical; and
  - Assessment, treatment plan, and responses to treatment plan.

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Claims - Documentation

- Medicare Documentation:
  - The medical record should be complete and legible;
  - The documentation of each patient encounter should include:
    - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
    - Assessment, clinical impressions or diagnosis;
    - Plan for care, and
    - Date and legible identity of the observer.

Claims - Documentation

- Medicare Documentation:
  - If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
  - Past and present diagnoses should be accessible to the treating and/or consulting physician; and
  - Appropriate health risk factors should be identified.

Claims - Documentation

- Medicare Documentation:
  - The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented; and
  - The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.

Claims - Documentation

- Medicare Documentation:
  - If a service is not documented, one can argue it did not happen.
  - There are numerous situations that may warrant the need to present documentation for services rendered. Document the service as close to when the service was furnished as possible. Late entries arouse suspicion and increase the likelihood of inaccuracies.

Claims – Documentation

- All claims submitted to Medicare for teaching physicians must reflect actual services provided, as reflected in the documentation found in the patient's chart.
- This includes documentation of the procedure or portion of the service performed by the physician and the physician's presence during the key portion of any service or procedure performed or billed to Medicare.

Claims - Documentation

- There must be procedures to prevent more than one claim from being submitted for the same service or for submitting a claim to more than one primary payor for the same service at the same time.
- There must be appropriate documentation to support costs claimed on the cost reports.

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Claims - Documentation

- Medicaid General Documentation Requirements:
  - Mandatory – all entries are legible to individuals other than the author, are dated (month, day and year), and are signed by the performing provider;
  - Mandatory – each page of the medical record documents the patient's name and Medicaid identification number; and
  - Mandatory – allergies and adverse reactions (including immunization reactions) are prominently noted in the record.

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Claims - Documentation

- Medicaid General Documentation Requirements:
  - Mandatory – the selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. The AMA's Current Procedural Terminology (CPT) descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.

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Claims - Documentation

- Medicaid General Documentation Requirements:
  - Mandatory – the history and physical documents the presenting complaint with appropriate subjective and objective information; and
  - Mandatory – the services provided are clearly documented in the medical records with all pertinent information regarding the patient's condition to substantiate the need for the services.

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Claims - Documentation

- Medicaid General Documentation Requirements:
  - Mandatory – medically necessary diagnostic lab and x-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans;
  - Mandatory - necessary follow-up visits specify time of return by at least the week or month; and
  - Mandatory – unresolved problems are noted in the record.

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Claims - Documentation

- Medicaid General Documentation Requirements:
  - Desirable – immunizations are noted in the record as “complete” or “up-to-date”;
  - Desirable – Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

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Claims - Coding

- Coding is the process of transforming descriptions of medical diagnoses and procedures into universal medical code numbers.
- Code Assignment:
  - Procedure Codes
    - Current Procedure Terminology (CPT); and
    - Healthcare Common Procedure Coding System (HCPCS).
  - Diagnosis Codes
    - International Classification of Disease (ICD) – 9 CM;
    - ICD – 10 (not implemented yet); and
    - Diagnosis Related Grouping (DRG) Assignment.

Claims - Coding

Procedure Codes:

- Numbers or alphanumeric codes used to identify specific procedures performed by medical professionals.

Examples of Procedure Codes:

- Healthcare Common Procedure Coding System (HCPCS);
- ICD-10 Procedure Coding System (not implemented yet) (International Classification of Diseases); and
- ICD-9-CM Volume #3 (subset of ICD-9-CM.)

Claims - Coding

Diagnostic Codes:

- Used to group and identify diseases, disorders, symptoms, and medical signs, as well as to measure morbidity and mortality.

- Commonly Used Diagnosis Codes:
  - ICD-9-CM (Volumes 1 & 2);
  - ICD – 10 (not implemented yet); and
  - ICPC-2.

Claims - Billing

- Once the procedure and diagnosis codes are determined, claims are edited prior to submission to ensure they meet requirements.
- Claims in error are to be corrected by the originating service area.
- The claim is usually billed by transmitting the claim to the payer using Electronic Data Interchange to submit the claim file to the payer directly or via a clearinghouse.

Claims – Submission Requirements

- Proper and timely documentation is received for physician and other professional services prior to billing.
- Claims are submitted only when documentation is maintained and available for audit and review.
- Physician and hospital records and medical notes are organized and legible so they can be audited and reviewed.

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Claims – Submission Requirements

- Documentation includes patient records, length of time spent conducting each activity, the identity of the individual providing the service and other hospital specific documentation guidelines.
- Diagnosis and procedures reported on the claim are based on the medical record and other documentation and that this information is available to the coding staff so that they may assign a correct code.

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Claims – Submission Requirements

- Billing Department and coding staff and consultants do not receive financial incentives to improperly code claims.

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Claims - Claims Submission

- Claims must be submitted within the filing deadlines established by the payors, for example Medicare and Medicaid require claims submission within 95 days of the Date of Service.
- Must be filed electronically – DDE submission is the only acceptable method currently.

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Claims - Claims Submission

- Provider must secure and maintain a patient's signature for all claims submitted.
- Signature is obtained through the assignment of benefits form completed at the time of service.

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FRAUD AND ABUSE

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Fraud and Abuse

- ***Fraud*** – making material false statements or representations of facts that an individual knows to be false or does not believe to be true in order to obtain payment or other benefit to which we would otherwise not be entitled.

- ***Abuse*** – practices that directly or indirectly result in unnecessary costs or improper payments for services which fail to meet recognized professional standards of care.

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Fraud and Abuse

- Entities Involved in Detecting Fraud and Abuse:
  - Department of Health and Human Services (HHS);
  - Centers for Medicare & Medicaid Services (CMS);
  - Office of Inspector General (OIG) of HHS;
  - Federal Bureau of Investigation (FBI);
  - Internal Revenue Services (IRS);
  - Intermediaries, Carriers, and DMERCs under contract with CMS;
  - Private Insurance Companies; and
  - Peer Review Organizations.

Fraud and Abuse

- Examples of Fraud:
  - Billing for a service never rendered
  - Inflating the prices of medications by switching to more expensive prescriptions, which were never authorized by physicians
  - Billing for motorized wheelchairs, while delivering less expensive scooters to clients
  - Accepting bribes
  - Forging signatures on prescriptions
  - Performing unnecessary medical procedures
  - Falsifying treatment plans or medical records

Fraud and Abuse

- Examples of Abuse and Waste
  - Accidentally documenting a procedure in the wrong medical record
  - An unintentional keypunch error that leads to an incorrect claim

False Claims Acts

- Federal
- State
- Deficit Reduction Act
- Texas OIG Act

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Federal and Texas False Claims Acts

- It is a violation of Federal and Texas laws to knowingly submit claims for payment with false and untrue information.
- This violation may occur with the submission of a claim, a statement in support of a claim, or conspiracy to submit a claim for payment.
- A claim is false or fraudulent when it asserts a material fact which is false, fictitious or fraudulent, or if the claim omits a material fact.
- In addition, the claim is submitted **knowingly** if the person or persons submitting it have actual knowledge, deliberate ignorance, or reckless disregard for its truth or falsity.

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Whistleblower Protections

- Both Federal and Texas False Claims Act contain *Qui Tam* provisions to protect whistleblowers:
  - Any person who reports an allegedly false claim to the federal or state government or participates in their investigation is protected by these acts;
  - Includes a prohibition on termination, demotion, suspension, threats, harassment and discrimination; and
  - Retaliation is also not permitted.

Deficit Reduction Act (DRA)

- Requires entities that receive or make annual payments of at least $5 million under a state Medicaid program to establish
  - written policies for its employees and contractors that provide detailed information about the Federal False Claims Act (FCA), administrative remedies, any state laws pertaining to civil or criminal penalties for false claims and statements, and
  - whistleblower protections under such laws to prevent and detect fraud, waste and abuse in Federal health care programs.

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OIG Exclusion Authority

- 42 U.S.C. § 1320a-7 gives the Office of Inspector General (OIG) the authority to exclude health care providers from participating in federal health programs, including Medicare and Medicaid for the conviction of certain criminal offenses and other actions.

OIG Exclusion Authority

- 42 U.S.C. § 1320a-7 gives the Office of Inspector General (OIG) the authority to exclude health care providers from participating in federal health care programs, including Medicare and Medicaid for the conviction of certain criminal offenses and other actions.
- An exclusion typically prevents the excluded individual or entity from being employed by, or under contract with, any practitioner, provider or supplier to provide any items and services reimbursed by a Federal health care program.

Penalties

- Civil:
  - Monetary; and
  - Exclusion.
- Criminal:
  - Monetary; and
  - Incarceration.

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Penalties

Civil Monetary Penalties under the Federal and State False Claims Acts:

- Federal penalties range from **$5,500** to **$11,000** per violation, *plus* **three times** the amount of **damages.**
- Penalties under state law are between $5,000 and $15,000, *plus* **two times** the amount of **damages**.

Civil Exclusion Penalties:

- OIG Exclusion Authority, 42 USC § 1320a-7.

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Examples in Harris County, TX

- 73 year old physician sentenced to 11 years in prison for cheating Medicare and Medicaid out of more than $14 million by prescribing unneeded motorized wheelchairs to patients. Marketers brought patients to the physician by the busload from other states.
- 33 individuals were indicted for felony theft after they billed Medicaid for adult diapers, wheelchairs, and other medical supplies that were never delivered to Medicaid patients, costing Medicaid $7.7 million.
- Pharmacist convicted of first-degree theft and sentenced to 23 years in prison and ordered to pay $621,000 in restitution for engaging in a scheme to significantly inflate the prices of medications by switching to more expensive prescriptions, which were never authorized by physicians, then billing Medicaid for the higher prices.

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OBLIGATIONS

Organizational Obligations

- Federal and State False Claims Acts;
- Medicare and Medicaid Provider;
- Enrollment Agreement;
- EMTALA;
- Texas Statutes;
  - Government Code; and
  - Local Government Code.

Emergency Medical Treatment and Active Labor Act

- Emergency Medical Treatment and Active Labor Act (EMTALA) requires all Medicare participating hospitals with a dedicated emergency department to:
  - Provide an appropriate medical screening examination to any individual requesting such examination;
  - Determine if the individual has an emergency medical condition; and
  - If the person has such a condition;
    - Stabilize that condition; or
    - Appropriately transfer the patient to another hospital.

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Personal Obligation

You are obliged to comply with the following:

- Federal and State False Claims Acts;
- HCHD Code of Conduct;
- HCHD Human Resources Policies; and
- Texas Government and Local Government Statutes.

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