Learning the Laws Behind Compliance

Save to myBoK

by Dorothy Grandolfi Wagg, JD, RHIA

With Vision 2006, AHIMA's Board of Directors challenged members to expand our knowledge base and professional horizons. One role that several HIM professionals have been asked to fill is compliance officer or manager. Generally, this role has led us down a familiar path—using our broad knowledge base and skill sets to oversee health information and billing in an often expanded and exciting role.

Our daily compliance work confronts us with complex ideas and laws. While we are certainly skilled in privacy and patient confidentiality issues, we have had to become immediately conversant with a whole realm of law, regulation, and rules promulgated by government agencies and third-party payers. These laws and regulations form the cornerstone of compliance, and it is critical that we understand their mandate and effect.

To be sure, thousands of laws and regulations affect healthcare delivery. However, in our roles as compliance leaders, it is critical that we become knowledgeable with, at a minimum, the following rules of law and their impact in this new HIM arena.

The federal government has several tools in its arsenal to combat healthcare fraud and abuse. These statutes have both criminal and civil sanctions. As with any crime, penalties can include imprisonment. Violating a civil statute results in fines and penalties. In both cases, Medicare providers risk sanctions that include suspension or debarment from it and other federal programs.

The Civil False Claims Act:[1] Enacted during the Civil War, the False Claims act was originally designed to penalize vendors who supplied the Union with inferior products or cheated the government outright. In recent years, this statute—which mentions neither Medicare nor healthcare—has come to protect against charging the government for services that were not provided. Under this law, a person who knowingly submits a false or fraudulent claim to the government or makes a false statement to get such a claim approved or paid will be liable for both damages and penalties. There is no requirement to prove that the defendant actually intended to commit fraud; plaintiff or prosecutors need only prove that the defendant had actual knowledge that the information was false, acted in deliberate ignorance of the truth, or acted with reckless disregard of the truth.

The Criminal False Claims Act:[2] Similar to the Civil False Claims act, this statute provides that persons in violation may be imprisoned and face restitution and significant fines. Convictions can result in mandatory exclusion from Medicare and state healthcare programs.

The Anti-Kickback Statute:[3] This federal law prohibits knowingly and willfully soliciting or receiving any remuneration (that is, anything of value) or knowingly and willfully offering remuneration, whether direct or indirect, overt or covert, in cash or in kind, in return for referring a patient for the furnishing of any item or service or purchasing, leasing, ordering, or arranging for the purchase, lease, or ordering of any item of service paid for in whole or in part by a federal program. For example, paying a physician for referrals would be prohibited. Since the enactment of this statute, relationships among providers have become more formal—with arm's-length transactions for goods and services clearly spelled out in written agreements—to preclude even the hint of impropriety. Many states have passed similar legislation prohibiting inducements for referrals for services for which other payers like managed care organizations or insurance companies are responsible.

Physician Self-referral Prohibitions (Stark I and II):[4] Concerned that physicians in particular were bilking the system by referring their own patients to their own services, Congress passed complex laws that forbade self-referral for a number of services. In 1989, Congress passed what is known as Stark I, which prohibits a physician from referring Medicare patients to a clinical lab in which the physician or an immediate family member has a financial interest.

In 1995, Congress passed Stark II, which extended the prohibition to other services. Now, physicians and/or immediate family members are prohibited from making referrals to any entity for the furnishing of "designated health services" if that physician or immediate family member has a financial interest in the entity to which the referral is being made. "Designated health service" include clinical labs, occupational therapy, physical therapy, orthotics/prosthetics, hospital services durable medical equipment, parenteral/enteral nutrition services and supplies, radiology, radiation therapy, home health services, and outpatient prescription drugs. For example, an orthopedic surgeon could not refer patients to his wife's physical therapy practice. This would taint not only the physician's referral, but also the physical therapy claim for payment for services.

Permissive and Mandatory Exclusion:[5] This federal law contains provisions to bar providers from participation in Medicare and all federal healthcare programs due to a criminal or other program violation. Mandatory exclusions ranging from five years to permanent apply with felony criminal convictions. Permissive exclusions allow debarment for a minimum of one year and are generally applied with misdemeanors.

Civil Money Penalty Law:[6] This federal statute allows the Department of Health and Human Services (HHS) to recover money damages involving false or fraudulent claims for items or services or certain other prohibited activities. In addition to paying restitution for false claims, the provider may be responsible to pay significant monetary penalties. The government can levy fines of up to three times the amount of damage caused by the defendant. Thus, a false claim of $100 can lead to penalties of restitution ($100) plus treble damages ($300), plus a fine of up to $10,000.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996[7] significantly changed the civil monetary penalty law by including penalties when a provider:

- engaged in patterns of upcoding
- engaged in patterns of claiming medically unnecessary items of services
- transferred remuneration to a Medicare beneficiary that is likely to influence him to order or receive items or services (including waiving coinsurance and deductibles for services)
- submitted a claim when the person has been excluded from the Medicare/Medicaid program, yet retains ownership or a controlling interest in an entity that still participates in Medicare or Medicaid

HIPAA greatly increased an already burgeoning area of federal, state, and private enforcement. It established four programs designed to assist with fraud enforcement:

- the Fraud and Abuse Control Program, established jointly by the Department of Justice and Office of the Inspector General to control healthcare fraud and abuse and conduct investigations relating to the delivery of heathcare services
- the Medicare Integrity Program, which directs HHS to enter into agreements with private companies to carry out fraud and abuse protections
- the Beneficiary Incentive Program, which encourages Medicare beneficiaries to report suspected fraud and abuse
- the Healthcare Fraud and Abuse Data Collection Program, designed to create a national healthcare fraud and abuse database in coordination with the National Practitioner Data Bank[8]

Mail and Wire Fraud:[9,10] Another arrow in the government's quiver for fraud prosecution and abuse claims are the statutes relating to mail and wire fraud. The laws prohibit placing in any post office or authorized mail depository any item to be delivered by the Postal Service that relates to fraud or using any wire service to execute such a scheme. Both mail fraud and wire fraud are felonies, punishable by up to $1,000 fine and imprisonment for up to than five years, or both.

Traditional HIM professionals' roles have required us to have broad knowledge and an understanding of medicine. Now, as medicine continues to have significant legal oversight, we need to extend that knowledge base to include the underpinnings of fraud and abuse and other relevant legal mandates.

Notes

1. 31 USC ß 3729.
2. 42 USC ß 1320a-7b(a).
3. 42 USC ß 1320a-7b(b).
4. 42 USC ß 1395 nn.

5. 42 USC § 1320a-7; see also www.dhhs.gov/progorg/oig for list of excluded and reinstated providers.
6. 42 USC ß 1320a-7a.
7. PL 104-191.
8. National Practitioner Data Bank, available at www.npdb.com.
9. 18 USC ß 1341.
10. 18 USC ß 1343.

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