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The Modern Age of Fraud and Abuse Compliance
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I. Legal Framework Overview

A. Governmental Oversight

1. Federal

a. U.S. Department of Health and Human Services (HHS)

b. Office of Inspector General (OIG) (part of HHS)

c. U.S. Department of Justice (DOJ)

d. Center for Medicare and Medicaid Services (CMS)

2. State of Wisconsin

a. Wisconsin Attorney General (AG)

b. Wisconsin Department of Health Services (DHS)

c. Wisconsin DHS Office of Inspector General (OIG)

3. Additional Groups to Know

a. Zone Program Integrity Contractors (ZPICs)

i. The primary goal of this program is to identify cases of suspected fraud, investigate them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped.

ii. ZONE 3 – Cahaba Safeguard Administrators includes the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin.

b. Recovery Audit Contractors (RACs)

To identify and correct Medicare improper payments by the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers.

B. Laws to Know

1. Anti-Kickback Statute (AKS)

a. 42 U.S.C. § 1320a-7b

b. Unlawful to knowingly and willfully, solicit or receive:

i. Any remuneration (directly or indirectly, overtly or covertly, in cash or kind)

ii. In return for:

(1) Referring any item or service reimbursable by federal health care programs, or
(2) Purchasing, leasing, ordering or arranging for (or recommending any of the same) any good, facility or service reimbursable by federal health care programs

c. Unlawful to knowingly and willfully, offer to pay:

i. Any remuneration (directly or indirectly, overtly or covertly, in cash or kind)

ii. To induce:

(1) Referring for any item or service reimbursable by federal health care programs, or

(2) Purchasing, leasing, ordering or arranging for (or recommending any of the same) any good, facility or service reimbursable by federal health care programs

d. Three necessary elements:

   i. Intentional Act

   ii. Direct or Indirect Payment of Remuneration

   iii. To Induce the Referral of Patients or Business

e. Statutory Exceptions and Safe Harbors:

   i. Discounts

   ii. Employees

   iii. Group purchasing organizations

   iv. Sale of a practice

   v. Referral services

   vi. Warranties

   vii. Investment interests

   viii. Space rental

   ix. Equipment rental

   x. Personal services and management contracts

   xi. Waiver of deductibles and coinsurance [1]

f. What is Remuneration?

   An extremely broad scope, whether in cash or in kind, and whether made directly or indirectly, including:

   i. Kickbacks

   ii. Bribes

[1] 42 C.F.R § 1001.952(a)-(k); *see also* 56 Fed. Reg. 35,952 (1991).

iii. Rebates

iv. Gifts

v. Above or below market rent or lease payments

vi. Discounts

vii. Furnishing of supplies, services or equipment either free, above or below market

viii. Above or below market credit arrangements

ix. Waiver of payments due

2. False Claims Act (FCA)

a. 31 U.S.C. §§ 3729-3733 – "Lincoln Law"

b. The federal FCA prohibits a person from "knowingly" submitting claims or making a false record or statement in order to secure payment of a false or fraudulent claim by the federal government.[2]

c. The statute specifically provides that the terms "knowing" and "knowingly" mean that a person:

i. has actual knowledge of the information;

ii. acts in deliberate ignorance of the truth or falsity of the information;

iii. acts in reckless disregard of the truth or falsity of the information."[3]

Therefore, no proof of specific intent to defraud is required. Under the False Claims Act, civil actions must be brought within six years after the date of the violation, or within three years after the date when material facts are known or should have been known by the government; in any event, no claims may be made more than 10

[2] 31 U.S.C. § 3729.
[3] *Id.* at § 3729 (b).

years after the date on which the violation was committed.[4]

d. Key elements:

i. False Claims

ii. Intent

iii. Materiality

iv. Causation

e. Key FCA Theories:

i. Upcoding/billing for services not rendered

ii. False certification of compliance with regulations

iii. Quality of care/worthless services

iv. Improper retention of overpayments

v. Anti-Kickback Statute/Stark Law

vi. "Causing" submission of false claims

f. The False Claims Act does not cover false tax returns. This FCA "tax bar" has been held to apply broadly whenever a false claim is made or a benefit is procured under the Internal Revenue Code, and is not limited to false income tax claims.[5]

[4] *Id.* at § 3731(b).
[5] 31 U.S.C. § 3729 (e) provides that "This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1954."

II. CMS Study in 2015

In September 2015, DHS and OIG released findings from the study *Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports*.[6]

A. Why was the study conducted?

Historically, Medicare has been vulnerable to ambulance transport fraud. In 2012, Medicare Part B paid $5.8 billion for ambulance transports, almost double the amount it paid in 2003. The study was conducted to scrutinize the spending in light of the rapid growth and funding of ambulance transports.

The study was conducted by analyzing claims data for 7.3 million ambulance transports during the first half of 2012. The aspects reviewed include transport destinations, transport levels, distance of urban transports, other Medicare services that beneficiaries received, and the geographic locations where the beneficiaries who received transport resided.

B. Findings

1. Medicare paid $24 million for ambulance transports that did not meet certain program requirements to justify payment.

2. Medicare paid $30 million for transports in cases which the beneficiaries did not receive Medicare services at the pick-up or drop-off locations, or anywhere else.

3. One in five suppliers had questionable billing.

4. More than half of all questionable transports were provided to beneficiaries residing in four metropolitan areas.

C. Recommendations

The overriding recommendation is for CMS/OIG to enhance existing fraud and abuse safeguards by taking the following steps:

1. Consider a temporary moratorium on ambulance supplier enrollment in targeted geographical areas.

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[6] Murrin, S., U.S. Dep't of Health and Human Servs. Office of Inspector General, *Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports* (2015).

2. Require ambulance suppliers to include the National Provider Identifier of the certifying physician on transport claims that require certification.

3. Increase monitoring of ambulance billing.

4. Determine the appropriateness of claims billed by ambulance suppliers and take appropriate action.

III. Examples of Recent Cases

A. *United States of America, et al. v. Navicent Health, Inc*., No. 5:15-cv-00152

On May 2015, Andre Valentine, a former paramedic with Navicent, Inc. filed a whistleblower lawsuit under the provisions of the False Claims Act. Mr. Valentine's claim focused on transports between hospitals. The OIG independently investigated billing of emergency ambulance transportation for services provided to patients from the hospital to destinations such as skilled nursing facilities and patient residences.

The investigation continued for 27 months, and revealed two schemes in violation of the FCA:

1. Non-emergency ambulance transports between hospitals billed at an inflated rate by claiming the ambulance trips were emergencies.

2. Billing on non-emergency ambulance transports of patients released from the hospital to their residences, nursing homes, skilled nursing facilities, hospital-based diagnostic clinic, or dialysis clinics as emergency transports. Navicent billed for these transports as emergency transports in violation of ambulance billing rules.

The case settled in August 2017 for $2.5 million and Navicent entered into a corporate integrity agreement.

B. *United States ex rel. Meehan v. Medstar Ambulance. Inc., et al.,* No. 13-cv-12495-IT (D. Mass)

The case was filed by a former employee in the Medstar billing office under the whistleblower provisions of the False Claims Act. The investigation found that Medstar submitted false claims to Medicare for ambulance transport services, from January 1, 2011 through October 31, 2014. Medstar submitted claims to Medicare for ambulance transport services that did not qualify as medically necessary, billed for higher levels of services than what the patients required and billed for higher levels of services than were provided.

In the January, 2017 Medstar Ambulance Inc., its four subsidiaries and its two owners agreed to pay $12.7 million to Medicare and enter into a corporate integrity agreement with OIG.

C. Other Recent Settlements

In each instance below, the ambulance company entered into a settlement agreement with the OIG to resolve allegations in which the company submitted false claims to Medicare for either: (a) emergency ambulance transportation to destinations such as skilled nursing facilities and patient residences that should have been billed at a lower non-emergency rate, or (b) non-emergency repetitive ambulance services between beneficiaries' residences or skilled nursing facilities and non-hospital based dialysis facilities.

1. On November 28, 2016, Mitchell-Jerdan Funeral Home, Ltd. (MJFH), an ambulance company in Mattoon, Illinois, agreed to pay $126,425.02.

2. On March 31, 2017, Freedom Ambulance, LLC (Freedom Ambulance), an ambulance company in Beeville, Texas, agreed to pay $846,563.92.

3. On March 31, 2017, EasCare, LLC, an ambulance company in Dorchester, Massachusetts, agreed to pay $255,768.14.

4. On October 27, 2016, American Paramedical Services, Inc. agreed to pay $187,480.12.

5. On September 16, 2016, Arkansas Excellent Transport, Inc. agreed to pay $35,208.35.

6. On May 5, 2016, Allied EMS Systems, Inc., of Petoskey, Michigan, agreed to pay $121,722.63.

7. On November 12, 2015, Shawano Ambulance Services, Inc. of Shawano Wisconsin agreed to pay $108,086.

IV. Understanding When Non-Emergency Transports Are Covered

A. Medicare pays for non-emergency ambulance transport only for the following circumstances:

1. When other forms of transportation could endanger the health of the client;

2. If the client has End-Stage Renal Disease (ESRD), needs dialysis and needs transportation to a dialysis facility;

3. If ambulance transportation is needed for the client to obtain treatment or diagnose for a health condition; and

4. If the client has a written order from a physician stating that ambulance transportation is medically necessary.

B. Medicare pays for non-emergency ambulance transportation to covered destinations for treatment, such as:

1. Hospitals

2. Dialysis centers

3. Treatment facilities like cancer treatment centers and outpatient MRIs

C. Medicare will not pay if the patient:

1. Can walk

2. Can be transported by a wheelchair

3. Can sit up in bed

4. Can be transported safely by any method other than an ambulance

V. Guidance for Establishing or Strengthening a Compliance Program

HHS published guidance regarding compliance programs for ambulance providers in 2003.[7] The elements of an effective compliance program include:

A. Development or strengthening of compliance policies and procedures

1. Tailor policies and procedures to the operation of the organization.

2. Must have executive-level and management support.

B. If possible, designate a compliance officer and compliance committee

1. Ensure that the management level employee designated as the compliance officer has the appropriate credentials and training.

[7] 68 Fed. Reg. 14245-14255 (Mar. 24, 2003).

2. Emphasize billing integrity, documentation of medical necessity, contracting, or healthcare fraud and abuse.

3. Empower the officer to do their jobs and have direct access to the CEO or other executives.

C. Conduct effective training and education

1. Create elements that become the culture of the organization.

2. Specific topics to cover include:

a. Documentation of medical necessity

b. Policy regarding documentation coaching

c. General billing process

d. Facility contracting and the Anti-Kickback Statute

e. Implementing dispatch triage processes

f. False Claims Act and fraud and abuse laws

g. HIPAA/HITECH

h. Compliance issue reporting and policy of non-retaliation

D. Develop internal monitoring and reviews. Helps detect and identify problems and to help reduce the future likelihood of problems, and respond appropriately to detected misconduct.

1. Documentation of medical necessity

2. Medicare/Medicaid billing practices

3. Repetitive patient transports

4. Facility contracted rates

E. Develop effective lines of communication

1. Mechanism for employees to submit good-faith reports of compliance violations.

2. Investigate all reports, document, keep the file and provide feedback to the reporting individual.

F. Enforce standards through well-publicized disciplinary guidelines

1. Create and enforce a well-publicized policy regarding violations of the policies and procedures and code of conduct.

2. Disciplinary actions regarding compliance violations should be documented thoroughly and usually include sanctions up to and including termination.

G. Respond promptly to detecting offenses and take appropriate corrective actions

1. Create a formal process for responding to detected offense.

2. Formal enterprise-wide guidelines for communicating with regulators and external auditors to ensure consistency across the organization.

3. Formal system to organize, track and record the outcome of all communications between the organization and regulators.