

KNOW ***THE LAW:***

ANTI-FRAUD REGULATIONS FOR MEDICARE AND MEDICAID

HEALTHCARE FRAUD IS A GROWING PROBLEM, AND HEALTHCARE PROVIDERS ARE IN A UNIQUE POSITION TO COMBAT IT.

When Medicare began in 1965, it didn't come with nearly as many regulations as it has today. Initially, there were no agencies specifically designated to prevent or address healthcare fraud, and very few legal protections. Fairly soon after the program's inception, it became clear that such infrastructure was greatly needed.

Nursing homes were the **particular targets** of Medicare scams, and the facilities became infamous for fraudulent billing practices and patient mistreatment. Years of concerted efforts to tackle these issues prompted the instatement of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977.

Healthcare fraud is prevalent not just because of people who maliciously commit it, but also because those around them may be unaware of the appropriate protocol and legislation. In addition to having an awareness of the various **types of healthcare fraud**, it's important to know which regulations are in place in the event that you do spot fraudulent activity.

1. FALSE CLAIMS ACT

The False Claims Act is a broad piece of legislation that prohibits the submission of false claims to Medicare or Medicaid. A false claim is any purposefully inaccurate billing statement submitted to the federal government. The fines incurred for FCA violations can be up to three times the defrauded amount, in addition to a maximum \$11,000 fee per false claim submitted. The penalty fees are applied to each individual claim.

RED FLAGS FOR FCA FRAUD

FCA fraud is usually committed in order to receive higher Medicare reimbursements. To achieve the highest possible reimbursement, offenders often create complex schemes to falsify claims. These schemes can involve the collection of Medicare information through patient recruiters or fraudulent billing practices like upcoding.

Other Medicare abuses may be unintentional, the result of an organizational or individual failure to properly record services. This can happen when healthcare facilities do not adequately allocate their resources to ensure that invoices are meticulously completed.

It is important that healthcare providers report any discrepancies on previous claims and reimburse Medicare accordingly, but infrequent, unintentional errors are unlikely to be considered FCA violations.

“The government is largely disinterested in prosecuting cases based upon mistakes or miscalculations,” explains Morgan & Morgan Complex Litigation Group attorney **James D. Young**. “The purpose of the False Claims Act is to root out fraud, not billing errors. There are numerous other regulatory mechanisms to hold providers accountable for their mistakes.”

2. PHYSICIAN SELF-REFERRAL LAW (A.K.A. STARK LAW)

The Stark Law prohibits physicians who own or invest in “designated health services” such as radiology, physical therapy, clinical laboratory services and home health services from referring Medicare and Medicaid patients to these service providers. Stark Law violations can be penalized without any demonstration that there was a specific intent to commit the offense. This is known as strict liability. Any violations are **subject** to fines and exclusion from federal healthcare programs.

In 2014, the Halifax hospital system in Daytona Beach, FL settled a lawsuit that involved Stark Law violations. Halifax was alleged to have billed Medicare for testing executed by oncologists who received unlawful incentive bonuses. This type of scheme would constitute an inappropriate financial relationship with a designated health service. The **case** had been set for trial, however Halifax chose to settle in March of 2014 by paying \$85 million to the federal government.

3. ANTI-KICKBACK STATUTE

The Anti-Kickback Statute makes it illegal for healthcare providers and their affiliates to pay unauthorized patient recruiters—in cash, trips, perks or otherwise—for assistance in procuring patient referrals or securing more business.

This statute can be violated both by the party providing the remuneration and the party receiving it. The consequences are significant: in addition to criminal penalties, physicians who violate the AKS can face fines up to \$50,000 for each individual kickback, in addition to triple the amount of the remuneration.

Kickback schemes are highly prevalent. In a recent **case**, a defendant was charged of AKS violations as part of a larger False Claims Act scheme that defrauded Medicare of over \$28 million. The defendant, Santiago Borges, used his transportation company to facilitate kickbacks to patient recruiters. In return, the recruiters helped three Miami mental healthcare facilities locate Medicare patients whose details could be submitted in false claims.

THE CO-PAY CONUNDRUM

One lesser known Anti-Kickback violation is the practice of waiving co-pays. This is a complex issue, because although the waiving of applicable copays is generally prohibited under Medicare and Medicaid, physicians are enabled on rare occasions to make a judgment call based on the documented economic hardship of the patient.

While co-pay waiving may sometimes be practiced out of goodwill, Young advises healthcare providers to avoid it.

“Co-pays exist to create consumer friction in obtaining services and goods. Without any skin in the game, patients would overutilize both goods and services. Therefore, waiving co-pay obligations, when done in order to induce a patient to use services, is an absolute violation of the federal Anti-Kickback Statute.

There are times when a waiver makes sense such as indigence or hardship, but the routine waiver of a patient’s copayment obligations implicates this prohibition because it reduces the amount that the patient pays for services, and may therefore induce the patient to seek more services that are payable by Medicare.”

4. EXCLUSION STATUTE

The Exclusion Statute ensures that any party who has been convicted of any type of healthcare fraud, healthcare-related criminal behavior, or felony charges related to controlled substances is not permitted to participate in federal healthcare programs. The statute also enables the Office of the Inspector General (OIG) to issue other exclusions at its discretion.

Anyone who falls under the Exclusion Statute cannot seek reimbursement for treating Medicare or Medicaid patients, nor can they receive other types of federal healthcare reimbursement. Employers are responsible for doing appropriate background checks to ensure that they neither employ nor contract any party to whom the Exclusion Statute applies.

The government has created these types of legislation not to penalize inevitable human error, but to encourage institutional accountability. Medicare and Medicaid patients rely on the sound intentions of their healthcare providers. Minor mistakes cannot always be prevented, but deliberate abuse of patient trust and taxpayer dollars absolutely can.



IF YOU ARE A HEALTHCARE WORKER, REPORTING MEDICARE/MEDICAID FRAUD IS YOUR RIGHT AND RESPONSIBILITY. OUR WHISTLEBLOWER TEAM WILL CONFIDENTIALLY REVIEW YOUR CASE AND PROVIDE THE LEGAL ADVICE YOU NEED. CONTACT US FOR A FREE EVALUATION.