RECENT INVESTIGATION AND ENFORCEMENT TRENDS

2016 Compliance and TPL Focused Training

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Recent Investigation and Enforcement Trends

I. Overview of the False Claims Act

II. Government Agencies / Contractors Involved

III. Targeted Enforcement Actions

IV. Recent Settlements and Decisions

V. Mitigating Risks
I. Overview of the False Claims Act
The False Claims Act

**THE GOVERNMENT’S FAVORITE WEAPON**

- The False Claims Act, 31 U.S.C. § 3729, *et. seq.*, authorizes the United States, or private parties, known as “relators”, acting on behalf of the United States, **to recover monetary damages** from parties who submit, or cause others to submit, fraudulent claims for payment by the federal government.

- **Key Points:**
  - Liability for submitting, or causing to be submitted, a false or fraudulent claim for payment; making or causing to be made a false record or statement in order to secure payment of a claim; or conspiring to get a false or fraudulent claim paid.
  - Materiality: The falsehood was material to the decision to pay the claim.
  - Scienter: “knew or should have known”; “deliberate ignorance” of truth or falsity; “reckless disregard” of the truth or falsity of the claim.

No Specific Intent Needed
Overpayments
“REVERSE” FALSE CLAIMS

- Penalties can be imposed on anyone who “knows of an overpayment” and fails to report and return it.
- Under this law, the retention of an overpayment beyond 60 days constitutes an “obligation” within the meaning of the FCA.
Qui Tam Relators

- The federal False Claims Act is a *qui tam* statute, meaning that private citizens ("relators") may file complaints alleging violations of the FCA under seal on behalf of the U.S. Government and may receive at least 15%, but not more than 30%, of any amount recovered, depending on whether the government intervenes.

- Once a whistleblower files a suit, the Department of Justice must decide whether to "intervene" (i.e., take over and prosecute the suit).

- If the government does not intervene, the case is unsealed and the whistleblower may proceed on his/her own.
The False Claims Act
EXAMPLES AND TYPES OF FALSE CLAIMS ACT ALLEGATIONS

- Inadequate documentation of services performed
- Billing for services that are of such poor quality they are deemed “worthless.”
- False Certifications
- Billing for Goods or Services not Provided
- Billing for the same procedure more than once
- Upcoding
## Home Health Enforcement

### OTHER KEY RISK AREAS

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td>Medical necessity, and eligibility for home health benefit</td>
<td>- Medically unnecessary skilled services</td>
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<td></td>
<td>- Services provided to patients who are not homebound</td>
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<td></td>
<td>- Lack of a qualifying service</td>
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<td>Documentation sufficiency and compliance with CMS requirements</td>
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<tr>
<td>Financial relationships with referral sources</td>
<td>- To steer beneficiaries to a particular HHA</td>
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<td></td>
<td>- To provide or prescribe unnecessary care</td>
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<td>Marketing practices</td>
<td>- Interactions with referral sources</td>
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<td></td>
<td>- Interactions with beneficiaries</td>
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<td>Home health aide certification and training</td>
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I. Government Agencies / Contractors Involved
Federal Government Agencies

CONCERTED EFFORTS TO COMBINE AND POOL RESOURCES

Federal Departments:

- Department of Justice (DOJ)
  - Offices of the United States Attorneys (USAO)
- Federal Bureau of Investigation (FBI)
- Department of Health and Human Services (HHS)
  - Office of Inspector General (OIG)
  - Office of Audit Services (OAS)
  - Office for Civil Rights
  - Office of Evaluations and Inspections (OEI)
  - Center for Medicare and Medicaid Services (CMS)
    - Center for Program Integrity (CPI): “Serves as CMS' focal point for all national and State-wide Medicare and Medicaid programs and CHIP integrity fraud and abuse issues.” (CMS/CPI Functional Statement)
State Departments:

- **Office of Attorney General**
  - Medicaid Fraud Control Unit - “Investigates and prosecutes health care providers who defraud the Massachusetts Medicaid program, known as MassHealth.” [http://www.mass.gov/ago/bureaus/hcfc/the-medicaid-fraud-division/](http://www.mass.gov/ago/bureaus/hcfc/the-medicaid-fraud-division/)

- **Office of Inspector General**
  - The Office's mission is to prevent and detect fraud, waste, and abuse in the expenditure of public funds. [http://www.mass.gov/ig/about-us/](http://www.mass.gov/ig/about-us/)
  - Bureau of Program Integrity monitors the quality, efficiency and integrity of public benefits programs.
Enforcement Environment

GOVERNMENT INVESTMENTS IN FRAUD ENFORCEMENT ACTIVITIES

Investments in State-of-the-Art Technologies

- CMS Fraud Prevention System
  - Identified or prevented $454 million in improper payments in FY 2014
  - 10-to-1 return on investment

Investments to Increase Collaboration

- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Medicare Fraud Strike Force
- Healthcare Fraud Prevention Partnership (HFPP)
# The Contractors

<table>
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<th>Medicare</th>
<th>Medicaid</th>
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<td>Medicare Administrative Contractors (MACs)</td>
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<td>Recovery Audit Contractors (RACs)</td>
<td>Medicaid RACs</td>
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<td>Zone Program Integrity Contractors (ZPICs)</td>
<td>Review-of-Provider, Audit and Education Medicaid Integrity Contractors (MICs)</td>
</tr>
<tr>
<td>Comprehensive Error Rate Testing (CERT)</td>
<td>State Medicaid Fraud Control Units (MFCU)</td>
</tr>
</tbody>
</table>
RACs: What do they do?

- Permanent program created by Tax Relief and Health Care Act of 2006
- Detect and correct past improper payments (over/under payments)
- Apply statutes, regulations, CMS coverage and billing policies and LCDs to make determinations
- 4 regions each with a different contractor
  - Region A (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York) - RAC Contractor: Performant Recovery, Inc.
- Section 6411(b) of Affordable Care Act ("ACA") expands use of RACs to all of Medicare and not just Part A and B
ZPICs: What do they do?

- Created by Medicare Prescription Drug, Improvement and Modernization Act of 2003
  - Move away from Program Safeguard Contractor concept which divided contracts by service line (e.g., Part A, B, Home Health, etc...)
  - Part A, B, DME, Home Health and Hospice
- Detect potential fraud in a targeted way and refer to OIG/DOJ for investigation/prosecution
- Review claims on a prospective and retrospective basis
- Initiate payment suspensions
- Respond to Request for Information from law enforcement
- Recommend administrative action against providers (e.g., exclusion, revocation of provider number, collection of overpayment)
Top ZPIC Issues

- Billing for services not furnished
- Pattern of overutilization
- Vacant supplier/provider location
- Medically unnecessary services
- Stolen provider / beneficiary info
- Schemes of collusion (e.g., kickbacks)

OIG November 2011 Report: Zone Program Integrity Contractors’ Data Issues Hinder Effective Oversight
## Medicaid RACs

**STATES / RACs MUST:**

| Coordinate audits with other auditing entities | Report fraud to Medicaid Fraud Control Units |
| Set limits on number and frequency of medical records for review | Adhere to 3 year look-back period |
| Maintain 1 FTE Medical Director who is a M.D. or D.O. | Hire certified coders unless state determines not needed |
| Develop education and outreach programs | Incentivize RACs to detect underpayments |
III. Target Enforcement Actions
Health Care Enforcement

2016 OIG WORK PLAN

FY 2015:

Expected Recoveries:
• $3 billion
  ➢ $1.13 billion in audit receivables
  ➢ $2.22 billion in investigative receivables

Exclusions:
• 4,112 individuals and entities

Civil/Criminal Actions
• 925 criminal
• 682 civil
Home Health Enforcement

HHS-OIG PRIORITIES

OIG 2016 Work Plan – Home Health

Compliance with PPS requirements

- Review documentation required in support of claims paid by Medicare
- Determine whether home health claims were paid in accordance with federal laws and regulations
- Prior OIG report found that one in four home health agencies had questionable billing
In 2013, about 3.5 million Medicare beneficiaries received home health services costing around $18 billion, from more than 12,000 HHAs.

Medicare spending for home health care has increased by 87% since 2002.
- Home health care spending accounts for 4% of Medicare fee-for-service spending.
- 2001-2013 – number of home health episodes rose from 3.9 to 6.7 million.
- 1997-2013 – therapy visits increased from 10% to 36% of visits.

According to OIG, since 2010, nearly $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit.

“Fraudulent home-based services are surging across the country”
-Special Agent in Charge Derrick L. Jackson, HHS-OIG Atlanta
November 12, 2014
Home Health Care Market

Health Care Spend is Growing

Large, Growing Market – Total Home Health Spend

($ in billions)

2010-2019 CAGR: 9.1%

Source: RBC Capital, NAHC
Home Health Care Market
Number of Agencies are Increasing

Number of Medicare Certified HHAs

(000’s)

Source: BB&T Research, MedPAC, NAHC
IV. Recent Settlements and Decisions
AG to investigate possible home health care fraud

Updated: Feb 4, 2016 - 9:39 AM

BOSTON (AP) — The state has asked Attorney General Maura Healey to investigate a dozen home health care service providers suspected of submitting fraudulent bills.

The Boston Globe (http://bit.ly/1Ks9FK5) reports that the Executive Office of Health and Human Services referred the providers to the attorney general’s Medicaid Fraud Division after reviewing internal data and fielding consumer complaints that pointed to possible fraud.

State officials did not detail what kind of wrongdoing they suspect. Medicaid fraud often includes billing for unnecessary services.

The state’s costs for providing home health services have been soaring. MassHealth, the state Medicaid program, is on track to spend more than $755 million on home health services in the current fiscal year, an 82 percent increase from two years earlier.

Massachusetts works with 195 home health providers overall.

Recent Settlements and Decisions

- **May 6, 2016** - The University of Pennsylvania Health System (UPHS) settled allegations of submitting false home health care billings to the Medicare program. UPHS paid $75,787 to settle allegations that Penn Care at Home violated the False Claims Act by submitting claims to Medicare for services not rendered and for services that were not reasonable or necessary.

- **April 18, 2016** - Henry Lora was sentenced to 108 months in federal prison and ordered to pay $30,278,542 in restitution for conspiring to commit health care fraud and conspiring to defraud the United States, receive health care kickbacks and make false statements relating to health care matters. Dr. Lora was the medical director of Merfi Corporation and in exchange for kickbacks and bribes, he wrote prescriptions for home health care and other services for Medicare beneficiaries that were not medically necessary or not provided. Dr. Lora also falsified patient records to make it appear as if the beneficiaries qualified for these services.
Recent Settlements and Decisions

- **April 18, 2016** - Diana Jocelyn Gumila, the manager of Suburban Home Physicians d/b/a Doctor at Home, was convicted of 21 counts of health care fraud and three counts of making false statements in a health care matter. Each count of health care fraud is punishable by up to ten years in prison, while each false-statement count is punishable by up to five years in prison. Ms. Gumila directed employees to perform in-home visits with patients who were physically capable of leaving their residences and not in need of the in-home treatment. Gumila also inflated the costs incurred by Medicare by directing employees to bill the treatment at the most complicated levels, even though the visits were typically routine and did not qualify for the elevated billing.

Evidence at trial included an audio recording in which Gumila can be heard telling a new doctor to “paint the picture” of patients so as to make them appear confined to their homes. Emails from Gumila also included one in which she referred to a physician who did not read orders before signing them as “the type of doctor we need [b]ecause he will just do what we tell him to do.”
Recent Settlements and Decisions

- **April 13, 2016** - A federal jury convicted a Dallas physician and three owners of home health agencies on various felony offenses, including conspiracy to commit health care fraud, stemming from their participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services. Each conspiracy and health care fraud count carries a maximum statutory penalty of 10 years in federal prison and a $250,000 fine. The obstruction of justice count and each false statement count carry a maximum statutory penalty of five years in federal prison and a $250,000 fine. Jacques Roy, M.D., owned/operated Medistat Group Associates, P.A., an association of health care providers who provided home health certifications and performed patient home visits. Cynthia Stiger and Wilbert Veasey, owned/operated Apple of Your Eye Healthcare Services, Inc., and Charity Eleda owned/operated Charry Home Care Services, Inc. The home health agency owners improperly recruited individuals with Medicare coverage to sign up for Medicare home health care services when the services were not medically necessary. Dr. Roy instructed his staff to certify Plans of Care, which indicated to Medicare and Medicaid that a had reviewed the treatment plan and deemed it medically necessary, when they were not. Nurses for the home health agencies also falsified visit notes to make it appear as though skilled nursing services were being provided and continued to be necessary.
Recent Settlements and Decisions

- **April 11, 2016** - Naseem Minhas, the owner and operator of TriCounty Home Care Services Inc. (TriCounty), a home health care agency pleaded guilty for paying a physician and recruiters to refer Medicare beneficiaries to TriCounty and sign medical documents falsely certifying that they required home health care. Minhas, assisted in creating fake patient files to make it appear as though the patients needed and received services that were unnecessary or not provided.

- **April 5, 2016** - Mohammad Rafiq, the owner and operator of Perfect Home Health Care (Perfect), a home health care agency, was sentenced to 57 months in federal prison and ordered to pay $3.4 million in restitution for paying physicians and recruiters to refer Medicare beneficiaries to Perfect and sign medical documents falsely certifying that they required home health care. Rafiq also directed patient recruiters and Perfect employees to pay cash kickbacks to Medicare beneficiaries in exchange for signing multiple blank physical therapy records.

- **April 1, 2016** - Carlos Rodriguez Nerey, a patient recruiter for D&D&D Home Health Inc. (D&D&D) and Mercy Home Care, Inc. (Mercy), was convicted of conspiracy to pay and receive health care kickbacks and of receiving health care kickbacks. Medicare paid more than $2 million to D&D&D and Mercy for those claims.
Recent Settlements and Decisions

- **March 30, 2016** - Dr. Warren Dailey was found guilty of conspiracy to commit health care fraud, false statements relating to health care matters, conspiracy to pay and receive health care kickbacks and payment and receipt of health care kickbacks. Dailey defrauded Medicare by authorizing Medicare beneficiaries for home health care when such services were not needed. Dailey agreed to sign Medicare authorization forms certifying services in exchange for a monthly flat fee from the home health owner. Dailey falsely certified that patients were homebound, that home health was medically necessary and that the beneficiaries were under his care. Dailey faces a maximum of 10 years in federal prison as well as a possible $250,000 fine.

- **March 24, 2016** - Amanda Moye Randolph, the former CEO of Karlise In-Home Care, a home health care provider, was sentenced to eight months in federal prison, to be followed by three years of supervised release, the first eight months of which must be served in some alternate form of incarceration. Ms. Randolph was also ordered to pay $136,574 in restitution. Between December 2008 and April 2014, Randolph knowingly concealed her employment at Karlise from the United States Social Security Administration and the United States Department of Health and Human Services during the application for, and continued receipt of, disability benefits and supplement security income benefits. An accounting completed by those two agencies concluded that Randolph received $80,735 in connection with these fraudulent schemes.
Recent Settlements and Decisions

- **March 24, 2016** - Muhammad Tariq, an owner of home health care and hospice companies in the Detroit area, pleaded guilty to conspiring to commit health care fraud and wire fraud. Tariq paid kickbacks, bribes and other inducements to physicians, as well as to marketers and patient recruiters, for beneficiary referrals to companies he

- **March 22, 2016** - Irina Krutoyarsky, The owner of HHCH Health Care Inc. was sentenced today to 60 months in prison for her role in a $7 million scheme to defraud Medicaid and engage in bribery, money laundering, and tax evasion. Krutoyarsky defrauded Medicaid by submitting false documents to the N.J. Board of Nursing, and fraudulently billing Medicaid for services not actually rendered to patients.

- **March 22, 2016** - Jenette George was convicted of violating the federal Medicare and Medicaid Anti-Kickback Statute and faces up to 15 years in prison. Ms. George was a marketer for Rosner Home Healthcare Inc. Between January 2008 and July 2012, Rosner officials paid kickbacks and bribes to doctors, marketers, medical office employees and nurses for referring patients.
Recent Settlements and Decisions

- **March 18, 2016** - Elaine Davis and Dr. Pramela Ganji were each convicted of conspiracy to commit health care fraud and health care fraud. Davis owned and controlled the operations of Christian Home Health Care Inc., and Davis and Ganji caused Christian to bill Medicare for home health care services that were not needed and/or were not provided. Davis paid employees to recruit new patients. Christian then sent the new patients’ Medicare information to Ganji to obtain signatures to certify that the patients qualified to receive home health care services when they did not. Ganji had often never seen these patients and these false certifications allowed Davis and Christian to bill Medicare for home health services and to conceal that the services were unnecessary. Between 2007 through June 2015, Christian submitted more than $34.4 million in claims to Medicare, a large number of which were fraudulent.

- **March 17, 2016** - Carlos Medina was sentenced to 82 months in federal prison for conspiring to commit health care fraud. In addition to his prison sentence, Mr. Medina must forfeit $3.6 million. Medina owned Doral Community Clinic Inc. and Advanced Medical of Doral Inc. Medina’s clinics sold prescriptions that were used to facilitate submission of false and fraudulent claims to Medicare by more than 20 home health agencies in the Miami area. Medicare paid more than $3 million in payments as a direct result of prescriptions sold by Doral and Advanced.
Recent Settlements and Decisions

- **March 2, 2016** - Mark T. Conklin, the former owner, operator and sole shareholder of Recovery Home Care Inc. and Recovery Home Care Services Inc. (collectively RHC) has agreed to pay $1.75 million to resolve a lawsuit alleging that he violated the False Claims Act by causing RHC to pay illegal kickbacks to doctors who agreed to refer Medicare patients to RHC for home health care services. Between 2009 and 2012, Mr. Conklin allegedly paid dozens of physicians thousands of dollars per month to serve as sham medical directors who supposedly conducted quality reviews of RHC patient charts. The physicians in many instances performed little or no work, but nevertheless received thousands of dollars from RHC and the government alleged that the payments were kickbacks intended to induce the physicians to refer their patients to RHC.

- **January 25, 2016** - JoAnna M. Ochieng pleaded guilty today to income tax evasion, conspiracy to commit health care fraud and money laundering relative to a scheme to defraud Medicaid of $436,305. Ochieng owned Healthy Solutions Home Health Services (Healthy Solutions) which provided nursing and home health services to Medicaid recipients and their families. Between November 2011 and March 2013, Healthy Solutions employees, under the direction of Ms. Ochieng, instructed parents who were providing home health care services to their children to “swap” time sheets with other parents who were also providing home health care services to their children, giving the false appearance that parents were providing home health services to children other than their own.
Recent Settlements and Decisions

- **January 22, 2016** - Khaled Elbeblawy was convicted of conspiracy to commit health care fraud and wire fraud and conspiracy to defraud the United States and pay health care kickbacks. Elbeblawy was the manager of Willsand Home Health Agency Inc. and the owner of JEM Home Health Care LLC and Healthy Choice Home Health Services Inc., all of which were home health agencies in Miami-Dade County. Between January 2006 and May 2013, Elbeblawy used the three companies to submit approximately $57 million in false and fraudulent claims to Medicare that were based on services that were not medically necessary, were not actually provided and were for patients who were procured through the payment of kickbacks to doctors and patient recruiters.

- **January 19, 2016** - Patricia Akamnonu, a registered nurse and an owner of Ultimate Care Home Health Services, Inc. (Ultimate), a home health company, was sentenced to 10 years in federal prison for conspiracy to commit health care fraud. Patricia Akamnonu, together with her husband, was ordered to pay approximately $25 million in restitution. Ms. Akamnonu maintained a valid Medicare group provider number for Ultimate in order to submit Medicare claims for home health services that were medically unnecessary or that were not provided to Medicare beneficiaries.
Recent Settlements and Decisions

- **January 6, 2016** - Evelyn Odoms was sentenced to three years probation, a special assessment of $100, and restitution in the amount of $2,055, for aiding and abetting health care fraud. Ms. Odoms, a licensed practical nurse, was supposed to teach a patient how to treat and handle different diagnoses, but she never observed the patient exhibit symptoms of the diagnoses and never taught the patient about the diagnoses. Ms. Odoms falsely documented services she was supposed to provide to the patient, documentation that Medicare relied upon to regulate Medicare providers.
V. Mitigating Risks
Compliance Program Activities

Develop and implement an effective corporate compliance program

- Ensuring Effectiveness
  - An effective compliance program is dynamic and evolves
  - One size does not fit all – an effective program is tailored to a provider’s structure and operation
  - Track guidance for government views as to what is necessary
    - HHS-OIG Compliance Program Guidance
    - Federal Sentencing Guidelines
    - Recent CIAs
  - Know your fraud and abuse risk areas – they change
Compliance Program Activities

AUDITING AND MONITORING

- Audit and Monitor High Risk Areas
  - Develop and adhere to a work plan that sets forth a schedule and scope of internal reviews
  - Consider periodic external reviews by independent third parties
  - Identify and refund overpayments within 60 days

- Evaluate Your Data to Identify Trends and Investigate Outliers
## Top Denial Reason Codes

### HOME HEALTH

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>32072</td>
<td>For home health claims (32X), the attending physician on the PECOS physician file has a termination date present and it is equal to or less than the claim from date of service.</td>
<td>The attending physician reported must be active in PECOS to be considered a valid attending physician for the home health patient.</td>
</tr>
<tr>
<td>55H20</td>
<td>This claim was denied after review. The provider’s determination of non-coverage is correct.</td>
<td>The charges on this claim are beneficiary liable. The beneficiary may be billed for these charges.</td>
</tr>
<tr>
<td>55H2B</td>
<td>Documentation submitted does not support homebound status.</td>
<td>The medical record must contain documentation to support the homebound status. Services should not be provided to patients that do not meet the criteria for homebound status.</td>
</tr>
<tr>
<td>55H2C</td>
<td>Medical necessity not supported as there is no OASIS present.</td>
<td>You must have the OASIS assessment for the episode for which records were requested as part of the records submitted for review.</td>
</tr>
<tr>
<td>55H3A</td>
<td>Skilled observation was not needed from the start of care (SOC).</td>
<td>Documentation of the beneficiary’s condition must support a covered level of care. Ensure that all records are submitted to Medical Review, when requested, for all services provided.</td>
</tr>
<tr>
<td>55H3V</td>
<td>Skilled nursing services were not medically necessary.</td>
<td>Documentation of the beneficiary’s condition must support services. Ensure services ordered meet the eligibility requirements.</td>
</tr>
<tr>
<td>55HTB</td>
<td>Medicare requirement for home health requires that a plan of care be established by the physician.</td>
<td>Only a physician may establish the patient’s plan of care.</td>
</tr>
<tr>
<td>56900</td>
<td>Requested medical records were not received within the 45 day time limit. Therefore, we are unable to determine the medical necessity of the services billed and this claim has been denied.</td>
<td>Be sure to submit requested records as soon as possible and within the time frame.</td>
</tr>
</tbody>
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https://www.ngsmedicare.com
Compliance Program Activities

AUDITING AND MONITORING

- Consider Engaging Legal Counsel to Conduct or Direct Auditing Activities You Want Protected By Privilege
  - Compliance effectiveness review
  - Targeted internal investigations

- Utilize Legal Counsel to Monitor and Manage Financial Relationships

- Ensure Background and Exclusion/Debarment Checks Are Regularly Conducted
  - Not only employees, but also independent contractors and vendors
  - Check both HHS-OIG LEIE database and GSA’s SAM database (www.sam.gov)
  - Also state Medicaid excluded provider lists
Compliance Program Activities

TRAINING AND EDUCATION

Designate a specific individual to be responsible for tracking and understanding regulatory changes and disseminating information to appropriate staff.

Importance of documentation training staff:
- Certification of plans of care
- Certification of terminal illness
- Face-to-face visits

Focused training for marketing staff on interactions with referral sources and beneficiaries.

HHS-OIG HEAT Provider Compliance Training Initiative resources.
Other Risk Mitigation Actions

- Track and log compliance questions, complaints and issues raised through the compliance program, steps taken to follow up, how issues were resolved, including corrective and preventative actions.
- Implement systems to ensure timely certifications, F2F visits, therapy reassessment visits:
  - EHRs can have features built-in to flag patients with upcoming requirements
  - Schedule IDGs sufficiently in advance to help monitor key timing requirements
- Have means to identify disgruntled employee or contractor:
  - Publicize compliance hotline to contractors, vendors
  - Conduct and document exit interviews, reviewed by compliance officer
- Monitor payor and contractor audits for patterns for signs of systemic issues:
  - Multiple audits of same/similar issues, multiple RAC or ZPIC audits
Government Overtures

- Vary in type and intensity
  - Contractor audits and additional documentation requests
  - Administrative subpoenas
  - OIG subpoenas
  - Civil Investigative Demands
  - Grand Jury subpoenas
  - Search warrant

- What to expect:
  - Unannounced requests
  - Clinical documentation demands
  - Rigorous data analysis
  - Potential for conflicting interpretation of Medicare guidelines
Useful Resources

- CMS Information

- CMS Regulation and Guidance

- CMS List Serve

- Medicare Claims Processing Manual (Chapter 10 – Home Health Claims)

- OIG Compliance 101 Education Materials
  http://oig.hhs.gov/compliance/101/index.asp

- OIG 2016 Work Plan
  http://oig.hhs.gov/reports-and-publications/workplan/index.asp#current
Useful Resources

- OIG Report to Congress

- OIG Exclusion List
  http://exclusions.oig.hhs.gov/

- OIG LEIE Downloadable Database
  https://oig.hhs.gov/exclusions/exclusions_list.asp

- GSA Excluded Party List
  https://www.epls.gov

- Texas Medicaid Exclusion List
  https://oig.hhsc.state.tx.us/Exclusions/Search.aspx

- HIPAA Breach Notification Rule
  http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html
Useful Resources

- Medicare Fee-For-Service Appeals

- Medicare Learning Network

- National Government Services (NGS)
  [http://www.ngsmedicare.com](http://www.ngsmedicare.com)