Institute Speakers

Trends in Federal Healthcare Enforcement Actions & Tips for Finance and Compliance Executives to Mitigate Risk

Robert Senska

Jack Wenik

by Robert Senska and Jack Wenik

Change is a predominant force in healthcare and not only must healthcare organizations plan for shifts resulting from administration changes, they must also navigate the dynamic landscape of new and evolving payment models and mechanisms for capturing and billing for services – such as with the implementation of ICD-10-CM (ICD-10). For healthcare executives, and the lawyers and consultants who assist them, the big questions are how will these changes in personnel affect fraud and abuse enforcement by the federal government, and more broadly, how within this regulatory environment can they successfully adjust to the new payment models and reimbursement mechanisms. As we describe below, it would appear that, based on recent events, most, if not all of the trends that began in the Obama administration and earlier will continue.

Healthcare Enforcement Will Continue to be a Priority

Although there has been some speculation that Attorney General Sessions would shift resources from healthcare fraud to violent crime and other initiatives, this seems to be belied by government statements and actions. Multiple high-level government officials at DOJ have stated since President Trump's election that healthcare fraud enforcement is and will remain a priority for DOJ. Similarly, if for no other reason than that healthcare fraud is a rich source of revenue for the government via fines, penalties and forfeitures, DOJ continues to commit significant resources to healthcare fraud enforcement. This has been reflected in the establishment of yet more healthcare fraud units and the recent "takedown" of 412 individuals in what was described as the largest healthcare fraud enforcement action in history.

The DOJ Will Continue to Press Individual Liability

Under the Obama Administration, DOJ promulgated the so-called "Yates Memorandum," which emphasized the prosecution of individuals for corporate wrongdoing. Perhaps most significant about the memorandum was its requirement that an organization must disclose all information about individual misconduct to receive cooperation credit and that DOJ would pursue civil litigation against individuals irrespective of their ability to pay a judgment. That DOJ intended to follow through on this policy with respect to healthcare executives was reflected in its $1 million settlement with the CEO of Tuomey Healthcare System, separate and apart from the government's $72.4 million settlement with the hospital, and its $1 million and $500,000 settlements with executives of North American Health Care, Inc., separate and apart from the company's $28.5 million settlement.

There has been no indication that DOJ under AG Sessions will back away from the policy of aggressively pursuing individuals both criminally and civilly for healthcare fraud and abuse. Indeed, in a May 10, 2017 Memorandum, AG Sessions directed all DOJ prosecutors to "charge and pursue the most serious, readily provable offense" in all criminal matters. Although aimed at narcotics and violent offenses, the memorandum appears to apply to fraud actions, including healthcare matters.

Reprinted with permission. Article originally appeared in Fall 2017 issue of *HFMA*.

Compliance Programs Will Continue to be Important and Subject to Government Scrutiny

The effectiveness of the compliance programs of healthcare providers will continue to be an important element of the government's assessment of whether or not to initiate an enforcement proceeding and the types of penalties to seek. In recent months, significant guidance has become available to guide healthcare providers. DOJ's Criminal Division in March of 2017 released guidance entitled *Evaluation of Corporate Compliance Programs.* Even more detailed guidance specific to healthcare was released in March 2017 in a joint effort of the Health Care Compliance Association and HHS-OIG (the "OIG Compliance Effectiveness Guidance"). The OIG Compliance Effectiveness Guidance provides a detailed template to evaluate all the elements of a healthcare compliance program.

In November of 2015, DOJ hired Hui Chen as a "full-time compliance expert." As a former compliance counsel and federal prosecutor, her role was to evaluate organization compliance programs as part of DOJ's process for resolving fraud investigations. Although Ms. Chen recently resigned from DOJ, there is every indication that DOJ will continue to look to the effectiveness of compliance programs in negotiating resolutions of healthcare investigations. Indeed, DOJ is actively seeking a replacement for Ms. Chen.

The Implementation of ICD-10 Presents Greater Compliance Challenges for Providers

Within a regulatory environment consistently focused on identifying and combatting fraud, healthcare providers must now also navigate much greater complexity and specificity in medical claim coding and documentation with the implementation of ICD-10. The federal government has made it abundantly clear in recent enforcement cases that instances of "upcoding" and/or an underlying failure to support medical necessity in the medical record can lead to liability. For example, on June 2, 2017, Fredericksburg Hospitalist Group, P.C. and 14 of its member shareholders agreed to pay approximately $4.2 million to the government to settle allegations of False Claims Act violations based on alleged upcoding of evaluation and management (E&M) codes in connection with the provision of hospitalist services to patients.

It is widely recognized throughout the industry that many providers were ill prepared for the drastic documentation changes required under ICD-10 with regards to, among other things, coding sequence of patient encounters, coding laterality, compliance of patient treatments and external cause codes. Even where providers are not engaged in actual fraud, there remains significant audit risk where providers have not caught up with these coding rule changes. Simply put, the inability to properly code services can lead to regulatory scrutiny, even if no fraud exists. The fact that the government is intent on ferreting out fraud increases the likelihood of regulatory audits of provider medical documentation and coding practices. Therefore, compliance leaders and financial executives alike must ensure proper training and systems are in place within their organizations to account for the many existing ICD-10 changes as well as new changes and adjustments which are constantly on the horizon. For example, for 2018 there will be 360 new codes, 142 deleted codes and 226 revised codes. These 2018 ICD-10-CM codes are to be used for discharges occurring from October 1, 2017 through September 30, 2018 and for patient encounters occurring from October 1, 2017 through September 30, 2018.

Failure to update and utilize correct codes not only can result in regulatory scrutiny and potential liability but also claims denials and/or delayed claims processing, thereby impacting revenue and cash flow. Furthermore, as our healthcare system continues with reform through programs such as PQRS, MACRA, MIPS and other quality assurance programs, services will be reimbursed much like the inpatient hospital claims that are based on diagnosis related groups ("DRG's"). A hallmark of such programs is that they are monitored and regulated based on the levels of specificity for the severity of a patient's presenting problem. Thus, as these payment systems continue to evolve, it will become even more important for provider documentation and coding to be at a higher level of specificity and in conformance with the ICD-10 rules.

Tips on Mitigating Risks in This Regulated and Complex Environment:

Given the current healthcare climate, it is evident that providers must engage in certain best practices in order to ensure compliance, mitigate risks, and put their organizations in the best position to capture revenue for legitimate, medically-necessary services performed. Here are some best practice tips that finance and compliance executives should consider to achieve these goals:

1. Finance, Compliance Departments and Executives **Must** Collaborate: All too often compliance departments work in isolation, separate and apart from finance departments within healthcare organizations. We suggest having a strong collaboration between compliance and finance, especially on issues impacting government repayments and other hot button compliance issues. Standing meetings to facilitate ongoing communications tend to be a good starting point.

2. Have A Consistent Auditing and Monitoring Plan: Through its 1998 Compliance Program Guidance for Hospitals and its 2005 Supplemental Compliance Program Guidance for Hospitals, the OIG made it clear that auditing and monitoring are critical elements of an effective compliance program. The OIG Compliance Effectiveness Guidance sets forth ideas on auditing and monitoring compliance program elements, such as periodically reviewing educational/training materials and policies and procedures to ensure that they are

continued on page 34

continued from page 33

up-to-date, understandable to staff and accurately reflect the organization's actual business processes. Finance and compliance departments can use this document to identify those particular elements that may be most applicable to their individual organizations, as they work on developing specific auditing and monitoring policies and procedures and the overall structure of their compliance programs.

3. Continue to Educate your Board: It is not news that it remains vital for boards to be apprised of the current healthcare regulations and government actions, as well as their roles and responsibilities, and now under Yates, the personal liability healthcare executives and Board members share. It is imperative for compliance and finance executives to continue to update and educate their boards in these areas.

4. Update your Annual Risk Assessment and Make Sure the Process Works: Now, more than ever, with the publication of the OIG Compliance Plan Effectiveness Guidance, organizations must have current risk assessments based on a comprehensive and functioning process for identifying and addressing company risks. There is no "one size fits all" solution to how the risk assessment process is resourced within a healthcare company. Often the risk assessment process falls to some combination of the compliance, finance, and internal audit functions. The important factor is not what department leads the risk assessment process, but that the process exists and that the appropriate departments and individuals within the organization are a part of the process and the implementation of any corrective actions.

Conclusion

It is safe to say that, even with major federal administration changes, identifying and curtailing healthcare fraud and abuse remains a major focus of federal government regulators. The returns on such activities continue to provide a strong incentive. Within such a regulatory environment, and with ever-growing complexities in medical coding and billing and evolutions of new payment models, healthcare finance and compliance executives must remain focused on finding ways to address operational, compliance and financial complexities to ensure their organizations remain compliant and financially successful.

About the Authors

Robert Senska is the General Counsel/Director of LW Consulting, Inc., a healthcare consulting firm. Rob can be reached at RSenska@LW-Consult.com.

Jack Wenik is a partner at the law firm of Epstein, Becker & Green in its healthcare and life sciences group. Jack can be reached at JWenik@ebglaw.com.

Join Rob & Jack for their presentation, "An Update for Healthcare Financial Executives Regarding Recent Government Actions, and Practical Tips on How to Mitigate Financial and Compliance Risk" on Wednesday, October 4th at 4p.m. in Studio 1.

Footnotes

[1]See, Reisinger, *As Priorities Shift at DOJ, Health Care Corporate Fraud Strike Force Gutted,* New Jersey Law Journal, July 10, 2017.

[2]*See, e.g.,* April 20, 2017 Remarks of Acting Principal Assistant Attorney General Trevor N. McFadden (commenting that "hospitals and healthcare companies around the country ... and their management will be held accountable for fraudulent misconduct."), available at https://www.justice.gov/opa/speech/acting-principal-deputy-assistant-attorney-general-trevor-n-mcfadden-justice-department-s; May 18, 2017 Remarks of Acting Assistant Attorney General Kenneth A. Blanco (commenting that he spoke to AG Sessions and that "The investigation and prosecution of healthcare fraud will continue; the department will be vigorous in its pursuit of those who violate the law in this area."); available at https://www.justice.gov/opa/acting-assistant-attorney-general-kenneth-blanco-criminal-division-speaks-american-bar.

[3]For example, the United States Attorney's Office for the Northern District of Illinois announced on July 18, 2017 the formation of a new healthcare fraud unit in Chicago. DOJ Press Release, July 18, 2017, *United States Attorney's Office in Chicago Creates New Unit to Prosecute Criminal Health Care Fraud Violations,* available at https://www.justice.gov/usao-ndil/pr/united-states-attorney-s-office-chicago.creates-new-unit-prosecute-criminal-health-care.

[4]DOJ Press Release, July 13, 2017, *National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses,* available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-charges-against-over-412-individuals-responsible.

[5]DOJ Press Release, September 27, 2016, *Former Chief Executive of South Carolina Hospital Pays $1 Million and Agrees to Exclusion to Settle Claims Related to Illegal Payments to Referring Physicians,* available at https://www.justice.gov/opa/pr/former-chief-executive-south-carolina-hospital-pays-1-million-and-agrees-exclusion-settle.

[6]DOJ Press Release, September 19, 2016, *The United States Settles False Claims Act Case With Nursing Home Company To Settle Allegations Of Medically Unnecessary Rehabilitation Therapy Services,* available at https://www.justice.gov/usao-ndca/pr/united-states-settles-false-claims-act-case-nursing-home

[7]The guidance document is available at https://www.justice.gov/criminal-fraud/page/file/937501/download.

[8]The HCCA/OIG guidance document is available at: https://oig.hhs.gov/compliance/101/files/HCCA-OIG-Resource-Guide.pdf.

[9]*See,* DOJ Solicitation for Compliance Counsel, available at https://www.justice.gov/legal-careers/job/attorney-advisor-compliance-counsel.

[10]See CMS ICD-10 information: https://www.cms.gov/medicare/coding/icd10/index.html.

[11]https://www.justice.gov/usao-edva/pr/fredericksburg-hospitalist-group-pays-42-million-settle-civil-fraud-case.

[12]https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-CM-and-GEMs.html.