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Physicians targeted for DME, home health fraud

Feds could impose fines of $10,000 per claim or triple damages and prosecute

It's no secret that the embattled home health and durable medical equipment industries remain at the top of the government's health fraud hit list. But a new special fraud alert, just released by the Office of the Inspector General, suggests that physicians soon could find themselves caught in the crossfire.

The alert concerns the improper use of certifications of medical necessity, which physicians must sign before Medicare will pay for home health care or a piece of durable medical equipment (DME). In many cases, the OIG acknowledges, it's the HHA or DME supplier who's committing the real fraud and reaping the financial rewards — but if your name's on the certification, you could nevertheless find yourself on the business end of a False Claims Act lawsuit.

"If they decide to audit you and the service or device was not medically necessary, you don't have much of a defense because your signature is right there on the paper," says **Anders Gilberg**, a government affairs representative with the Medical Group Management Association in Washington, DC.

Gilberg adds that improper certifications likely will remain a hot topic with the OIG for some time to come. That's because recent federal audits, conducted both by OIG and the Health Care Financing Administration, have suggested that Medicare may be losing literally billions of

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Defend yourself against DME fraud charges

Given that the feds are set to tighten their scrutiny on physicians' relationships with durable medical equipment (DME) suppliers, how can you be sure that the companies you're dealing with are reputable? The disturbing answer is, you really can't.

With home health care, you're on surer ground, experts say. After all, physicians must develop a plan of care to certify medical necessity, and that plan must be reviewed periodically and adjusted as the situation warrants, says **Ben St. John**, a

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Protect yourself with billing company's compliance plan

With the dust settling on the Office of the Inspector General's newest model compliance guidance, many physicians worry that the government has effectively turned third-party billers into a new class of government informer.

Ironically, however, now that the rules of the game have changed, your billing company's compliance plan could be your greatest asset when it comes to fending off false claims allegations, experts say.

If a billing company doesn't have a compliance program, then it's harder to establish that it has effective safeguards against billing errors and outright fraud, says **L. Stephan Vincze**, president and CEO of Vincze & Frazer and a consultant to the Bethesda, MD-based International Billing Association. Ultimately, the physician practice group is responsible for the correct submission of bills. So if you don't have a compliance plan and the billing company you

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work with doesn't have one, then your potential exposure to liability under the False Claims Act increases dramatically.

"The standard in the False Claims Act is a 'reckless disregard,'" says Vincze, who helped draft the OIG's compliance guidance for billers. "An astute prosecutor could effectively argue in any court that, with all the publicity surrounding compliance and all the associations making information available, not to have a program in place is a reckless disregard of trying to prevent fraud. If you employ a company without a compliance plan, then it can be presumed that you're assuming the risk that the company may be out of compliance. And the way these things work, if a grenade goes off, shrapnel's going to go everywhere and hit everybody."

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If a third-party biller is meeting the requirements of the OIG's plan, Vincze adds, you can at least be assured that the company is training its coders and auditing its own procedures to make sure it's documenting properly. You and your staff don't have to be the watchdog for its billing process.

To find out where you and your billing company stand, Vincze recommends reviewing your contract to find out whether it addresses any compliance responsibilities. In all likelihood, it doesn't. If that's the case, request a meeting with a billing company representative so you can amend the contract to spell out exactly who's responsible for what. The idea is to eliminate the possibility of nasty surprises in case something goes wrong and federal investigators become involved.

In your negotiations with the billing company, insist at a minimum on the following points, Vincze recommends:

- The billing company will agree to include language in the contract stating that it will implement and maintain an effective health care billing compliance program that includes the seven elements for effective programs as outlined in the OIG compliance guidance.
- If the billing company does the coding, it must agree to provide specific annual training to its coders on improper coding practices, coding documentation requirements, confidentiality requirements, communication reporting requirements, and basic government and private payer reimbursement principles.
- The company will agree in the contract to maintain current coding and billing reference materials for its coders.
- It will agree to conduct regular periodic audits of credit balances.
- It will take all reasonable steps to ensure data integrity in computer systems.

Vincze also recommends including language in the contract that spells out the reporting structure if fraud is suspected.

Basically, if the billing company believes that the physician or practice group is knowingly submitting false documentation to get reimbursed, then under the guidance, it's supposed to refrain from submitting the claim and notify the physician of its concerns. "The hope is that will be the end of the matter and it will be corrected," Vincze says. "This is a ticklish area, but my point is that the whole process should be included in the contract as something people know up front will happen." ■

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dollars annually because of poor documentation and what the government considers physicians' "laxity" in approving medically unnecessary DME and home health care for beneficiaries.

"The problem is that too often, it's a case of the tail wagging the dog," says **Sandra Anthony**, with the anti-fraud unit at Columbia, SC-based Palmetto Government Benefits Administration, one of the nation's four DME regional carriers. Instead of physicians initiating the discussion about whether something is medically necessary, she says, it's often the DME suppliers who drive the debate. "Because of the competition that's out there, the DME suppliers are getting to the patients directly and telling them, 'We can get this piece of equipment for you, but we need to have your doctor's certification or prescription.' Then the family or the beneficiary puts the heat on the physician."

Ben St. John, an OIG spokesman, agrees that in cases where the physician doesn't stand to gain financially, signing certifications is often done as a courtesy to the beneficiaries, their family, or to the provider of services. "Some take the attitude that a beneficiary may not meet the letter of the law, but close enough."

The fraud alert makes OIG's response to that practice very clear: If you sign certifications without ensuring that all the criteria for medical necessity are met, you could find yourself in very hot water. That could mean fines of up to $10,000 per false claim plus triple damages, criminal prosecution, and a host of administrative sanctions. And if the government suspects a DME company was paying you for your signature, you could face penalties under the Anti-Kickback Statute as well.

"Physicians need to be reminded that if they put their name on a certification of medical necessity, they're going to be facing a higher level of scrutiny," Gilberg says. "This is something the OIG is definitely going to be focusing on. It's not going away."

Specifically, the OIG stresses that before ordering home health care for a Medicare patient, physicians must:

- certify that the patient is homebound, under physician care, and in need of intermittent skilled nursing care, physical therapy, or speech therapy;
- establish and review a plan of care for the patient.

In ordering durable medical equipment, physicians must submit to the supplier a written order or prescription that is dated and signed and lists the patient's name, address, diagnosis, the item needed, the length of time it is expected to be needed, and the start date, if appropriate. DME suppliers must maintain the physician's original written order or prescription in their files. ■

OIG targets certifications of medical necessity

Here are a few examples of inappropriate or fraudulent certifications already uncovered by the Office of the Inspector General:

- A physician knowingly signs a number of forms provided by a home health agency that falsely represent that skilled nursing services are medically necessary in order to qualify the patient for home health services.
- A physician certifies that a patient is confined to the home and qualifies for home health services, even though the patient tells the physician that her only restrictions are due to arthritis in her hands, and she has no restrictions on her routine activities, such as grocery shopping.
- At the request of a DME supplier, a physician signs a stack of blank certificates for transcutaneous electrical nerve stimulator (TENS) units. The supplier later completes the certificates with false information in support of fraudulent claims for the equipment, which it submits to Medicare.
- A physician signs CMNs for respiratory medical equipment falsely representing that the equipment was medically necessary.
- A physician signs CMNs for wheelchairs and hospital beds without seeing the patients, then falsifies his medical charts to indicate that he or she treated them.
- A physician accepts from $50 to $400 from a DME supplier for each prescription he or she signs for oxygen concentrators and nebulizers. ■

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spokesman for the Office of the Inspector General. "So a physician would probably have greater awareness as to the circumstances of what's being delivered in the way of care," he says.

With DME suppliers, however, the physician merely sends the prescription to the DME supplier, who must keep that paperwork on file. Physicians are not automatically notified about subsequent bills submitted to Medicare. DME suppliers that have run into trouble with the law before are listed on the OIG's web site (http://www.dhhs.gov/progorg/oig/), but the list may not help to identify fly-by-night companies or companies that are currently under investigation by either the OIG or a DME regional carrier.

That's not to say that help isn't available, however. "We have a lot of information to share with our physician community," says **Sandra Anthony**, with the anti-fraud unit at Palmetto Government Benefits Administration in Columbia, SC. "There are advisories available, and they have access to us." Ultimately, however, the best defense against fraud charges is to be scrupulous in your own documentation and wary of aggressive suppliers who, for example, approach you with amendments to DME prescriptions or offer to reduce your burden by filling out part of the paperwork for you. ■

Don't let donations turn into hospital kickbacks

If a local hospital is pressuring you to donate to the hospital's charitable foundation, you could end up as a test case for the OIG. That's because even something that seems innocuous, like charitable donations, could be construed as a kickback arrangement.

Critics say hospital-based physicians often feel coerced to offer donations, and hospital-based physicians are especially vulnerable. For example, a hospital might indicate that its exclusive contract with a specialist might be awarded to another doctor if a target for donations isn't met, says **Neil Caesar**, an attorney in Greenville, SC.

The Office of the Inspector General already has warned hospitals not abuse their charitable status, notes **Tom Greeson**, an attorney at Hazel and Thomas in Falls Church, VA. Greeson says he believes the agency will prosecute more kickback cases now that Congress has given it authority to levy administrative penalties for kickbacks, rather than having to go through lengthy criminal trials.

Now, OIG can threaten to impose administrative penalties of up to $50,000 plus triple damages per violation, which providers might prefer to a long, expensive court battle.

While physicians may consider themselves victims in this, anyone who solicits or pays to get business could be found guilty of violating the statute. So how should you respond to high-pressure solicitations? "Just tell the hospital that your lawyer says this isn't a good idea. And then ask them what their lawyer thinks," Caesar says. ■

OIG approves physician plan to invest in HMO

Physicians with spare cash and an itch to invest should pay attention to this one. The latest OIG advisory opinion gives a thumbs-up to doctors who want to invest in a managed care organization.

In the opinion (No. 98-19), a company with an HMO and a preferred provider subsidiary will sell an interest — only described as less than 15% — to an independent physician association (IPA) with 2,200 shareholder-physicians. In return, the IPA will become the exclusive physician provider panel for the company's managed care business, and it will sign physician service agreements with its doctors to service the HMO. In addition, the IPA will sign 10-year contracts to handle management and administrative services for the HMO.

OIG concluded the deal poses a minimal risk of kickbacks. First, much of the HMO's business is with group insurance, so doctors can't influence referrals. Second, profits from the venture will flow through the IPA, not the physicians. Most importantly, distribution will be based on ownership in the IPA and not the value of referrals.

While this kind of joint venture might hold promise for some IPAs, experts caution that the advisory opinion only examines the venture in light of the anti-kickback statute. It doesn't address whether there are potential problems with the Stark self-referral laws. ■