COMPLIANCE CONNECTION

MIDLAND HEALTH
Compliance HOTLINE
855•662•SAFE (7233)
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ID# is required to submit a report.

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This newsletter is prepared monthly by the Midland Health Compliance Department and is intended to provide relevant compliance issues and hot topics.

IN THIS ISSUE

FEATURE ARTICLE
Doctor Convicted for COVID-19 Health Care Fraud Scheme

Midland Health PolicyTech
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DID YOU KNOW…

FRAUD & ABUSE LAWS EXAMPLES

The five most important Federal Fraud and Abuse Laws that apply to physicians are:

1. ***False Claims Act (FCA):*** *A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than actually provided.*
2. ***Anti-Kickback Statute (AKS):*** *A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals.*
3. ***Physician Self-Referral Law (Stark law):*** *A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest.*
4. ***Exclusion Authorities:*** *Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.*
5. ***Civil Monetary Penalty Law (CMPL):*** *Includes making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.*

Resource:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

MIDLAND HEALTH

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Office of Public Affairs
U.S. Department of Justice

Doctor Convicted for COVID-19 Health Care Fraud Scheme

A federal jury in Baltimore convicted a Maryland doctor for submitting over $15 million in false and fraudulent claims to Medicare and a commercial insurer for patients who received COVID-19 tests at his testing sites.

According to court documents and evidence presented at trial, Ron Elfenbein, 49, of Arnold, was an owner and the medical director of Drs ERgent Care LLC, dba First Call Medical Center and Chesapeake ERgent Care. Drs ERgent Care operated multiple drive-through COVID-19 testing sites in Anne Arundel and Prince George's counties. Elfenbein instructed the employees of Drs ERgent Care that, in addition to billing for COVID-19 tests, the employees were to bill for high-level evaluation and management visits. In reality, these visits were not provided to patients as represented. Rather, Elfenbein instructed his employees that the patients were "there for one reason only – to be tested," that it was "simple and straightforward," and that the providers were "not there to solve complex medical issues."

Elfenbein ordered these high-level visits to be billed for all patients, including those who were asymptomatic, who were getting tested for COVID-19 for their employment requirements, and who were being tested for COVID-19 so that they could travel. Elfenbein, through Drs ERgent Care, caused the submission of millions of dollars in claims to Medicare and a commercial insurer for tens of thousands of high-level visits that were not provided as represented and were ineligible for reimbursement.

The jury convicted Elfenbein of five counts of health care fraud. He is scheduled to be sentenced on Nov. 7 and faces a maximum penalty of 10 years in prison on each count. Elfenbein is the first doctor convicted at trial by the Justice Department for health care fraud in billing for office visits in connection with patients seeking COVID-19 tests. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Read entire article:
https://www.justice.gov/opa/pr/doctor-convicted-covid-19-health-care-fraud-scheme

DID YOU KNOW…

WHAT DOES THE HIPAA PRIVACY RULE DO?

The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information. ***It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.***

Read entire article:
https://www.hhs.gov/hipaa/for-individuals/faq/187/what-does-the-hipaa-privacy-rule-do/index.html#:~:text=The%20HIPAA%20Privacy%20Rule%20for,and%20release%20of%20health%20records.

MIDLAND HEALTH

MIDLAND HEALTH POLICYTECH

MIDLAND HEALTH

POLICYTECH® Policy & Procedure Management

Compliance Program Progressive Discipline Policy

POLICY: Corrective action shall be imposed as a means of facilitating Midland Memorial Hospital's Compliance Program Plan and overall compliance program goal of hospital-wide compliance. Corrective action plans shall assist Midland Memorial Hospital employees, agency staff, medical staff, allied health professionals, vendors, volunteers and students ("Workforce Members") to understand specific issues and reduce the likelihood of future non-compliance. Corrective action, however, shall be sufficient to effectively address the particular instance of non-compliance and should reflect the severity of non-compliance and the Workforce Member's past record of adherence to compliance standards.

1. Basis for Corrective Action: Internal investigation reports, audit reports, consultant reports, reports of questionable practices and/or a person having knowledge of a violation and failing to report such violation may form the basis for imposing corrective action.
2. Elements of a Corrective Action Plan:
   - **a.** As appropriate given the nature of the non-compliance, a corrective action plan shall include, but will not necessarily be limited to, the following:
     - **i.** A resolution of specific problems identified;
     - **ii.** A recommendation to repay or not bill inappropriate claims;
     - **iii.** As directed by hospital counsel, a report to appropriate government authorities about the non-compliance;
     - **iv.** A recommended policy and/or procedure to modify any improper billing practices to reduce the likelihood of recurrence and to monitor any necessary adoption of and compliance with the recommendations;
     - **v.** Additional mandatory education and training for Workforce Members who are the subject of the corrective action;
     - **vi.** Other corrective action measures as required by hospital administration;
     - **vii.** Focused reviews of relevant documentation for a defined period of time;
     - **viii.** Other reasonable corrective measures calculated to ensure adherence to the compliance program.
   - **b.** The Compliance Officer shall follow up and audit corrective action plans to determine whether the corrective action plan is being followed and is effective. The failure of an individual subject to a corrective action plan to adhere to the plan shall be grounds for further corrective action.

Read entire Policy: Midland Health PolicyTech #3887
"HIPAA Section 14.1: Compliance Program Progressive Discipline Policy"

Midland Health PolicyTech Instructions

Click this link located on the Midland Health intranet "Policies"
https://midland.policytech.com/dotNet/noAuth/login.aspx?ReturnUrl=%2f

IN OTHER COMPLIANCE NEWS

LINK 1

Ransomware Attack on Prospect Medical Holdings Affects Facilities in Multiple States

https://www.hipaajournal.com/ransomware-attack-on-prospect-medical-holdings-affects-facilities-in-multiple-states/

LINK 2

1.7 Million Oregon Health Plan Members Affected by MOVEit Hack

https://www.hipaajournal.com/1-7-million-oregon-health-plan-members-affected-by-moveit-hack/

LINK 3

700,000 Highly Sensitive School Records Exposed Online

https://www.hipaajournal.com/700000-highly-sensitive-school-records-exposed-online/

LINK 4

Up to 170,450 Patients Affected by Cyberattack on the Chattanooga Heart Institute

https://www.hipaajournal.com/170450-cyberattack-the-chattanooga-heart-institute/

FALSE CLAIMS ACT & ANTI-KICKBACK STATUTE

Watermark Retirement Communities to Pay $4.25 Million for Allegedly Receiving Kickback in Violation of the False Claims Act

Watermark Retirement Communities LLC, a senior living community operator based in Tucson, Arizona, that manages 79 retirement homes across the country, agreed to pay $4.25 million to resolve allegations that it violated the False Claims Act by soliciting and receiving a kickback from a nationwide home health agency (HHA) operator in order to facilitate referrals from Watermark retirement homes.

The United States alleged that the HHA operator purchased two of Watermark's HHAs in Arizona to induce referrals of Medicare beneficiaries living in Watermark residential communities. The scheme was designed around eight Watermark retirement homes in five states (Arizona, Connecticut, Delaware, Florida and Pennsylvania) where the two companies had overlapping operations. The United States alleged that from Jan. 1, 2014 through Oct. 31, 2020, Watermark caused the HHA operator to submit false claims for payments to Medicare for services provided to Medicare beneficiaries referred as a result of the kickback transaction. The Antikickback Statute prohibits parties who participate in federal health care programs from knowingly and willfully soliciting or receiving any remuneration in return for referring an individual to, or arranging for the furnishing of any item or services for which payment is made by, a federal health care program.

"It is imperative that decisions about the care provided to federal health care beneficiaries are not undermined by the payment of kickbacks," said Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division.

Read entire article:
https://www.justice.gov/opa/pr/watermark-retirement-communities-pay-425-million-allegedly-receiving-kickback-violation

FALSE CLAIMS ACT

Health Care Provider Agrees to Pay $5 Million for Alleged False Claims to California's Medicaid Program

Lompoc Valley Medical Center (LVMC), a California Health Care District that operates multiple health care providers, including a hospital and several clinics, in Lompoc, California, has agreed to pay $5 million to resolve allegations that it violated the False Claims Act and the California False Claims Act by causing the submission of false claims to California's Medicaid program (Medi-Cal) related to Medicaid Adult Expansion under the Patient Protection and Affordable Care Act (ACA). Pursuant to the ACA, beginning in January 2014, Medi-Cal was expanded to cover the previously uninsured "Adult Expansion" population – adults between the ages of 19 and 64 without dependent children with annual incomes up to 133% of the federal poverty level. The federal government fully funded the expansion coverage for the first three years of the program. Under contracts with California's Department of Health Care Services (DHCS), Santa Barbara San Luis Obispo Regional Health Authority, doing business as CenCal Health (CenCal), arranges for the provision of health care services as a county organized health system under Medi-Cal in Santa Barbara County and San Luis Obispo County, California, by contracting with providers such as LVMC to provide health care services to Medi-Cal patients. Under its contractual arrangement with DHCS, CenCal received funding to serve the Adult Expansion population.

Read entire article:
https://www.justice.gov/opa/pr/health-care-provider-agrees-pay-5-million-alleged-false-claims-californias-medicaid-program

Do you have a hot topic or interesting Compliance News to report?

If so, please email an article or news link to:

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