Lessons Learned from Recent Physician Practice Enforcement Actions

Anna Grizzle
Partner
Bass, Berry & Sims PLC

Shannone Raybon
Managing Counsel
CareSpot

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Enforcement Actions Focused on Billing and Coding Practices

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Billing and Coding Practices Hypothetical

- Physician owns walk-in clinics where other providers also provide services
- Claims are billed under the incorrect provider
- Claims also list the wrong service
- Claims lack supporting documentation
- Services performed lack medical necessity

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Zahid Aslam, M.D. – Criminal Plea and Settlement

- $3.07 million settlement and 30 month prison sentence to resolve health care fraud allegations
  - Physician also surrendered medical licenses, excluded from billing federal healthcare programs and subject to removal by immigration authorities as non-citizen
- Physician made false representation on loan application
- Physicians' walk-in clinics submitted claims that were not medically necessary, listed the wrong rendering provider, listed the wrong service, and lacked supporting documentation

https://www.justice.gov/usao-de/pr/physician-and-medical-practice-plead-guilty-making-false-statement-financial-institution

https://www.justice.gov/usao-de/pr/former-delaware-physician-sentenced-30-months-imprisonment-making-false-statement

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Billing and Coding Practices Hypothetical

- Physician performs office-based procedures
- Physician also sees patients for E/M visit on same day as procedure
- Claims billed using Modifier 25 to signify a separate E/M service was performed an the same date as procedure
- Urologist does not document separate E/M service

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FWC Urogynecology, LLC - Settlement

- Network of urogynecology practitioners pay $1.7 million to resolve FCA matter
- Group billed government healthcare programs using Modifier 25 to signify a separate E/M service performed on the same date as another procedure when no separate service was performed

https://www.justice.gov/usao-mdfl/pr/fwc-urogynecology-llc-agrees-pay-17-million-settle-false-claims-act-liability-misuse

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Billing and Coding Practices Hypothetical

- Physician practice uses NPPs for services
- Bills Medicare patient visits and treatments performed by NPP as "incident to" physician services
- Supervising physician not available or present in office
- Suggestions that billing claims at "incident to" rate are false and incorrect brought to physician's attention but ignored
  - Physician encouraged billing staff to falsely bill services at "incident to" rate

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Multiple Physicians - Settlement

- $690,441 settlement by Dr. Yasin Khan, Dr. Elizabeth Khan, Dr. Dong Ko, Westfield Hospital and affiliated entities including a related pain clinic, Lehigh Valley Pain Management, to resolve FCA billing allegations
- Defendants billed services performed by non-physicians as "incident to" physicians when physicians were away from the office or otherwise incapable of supervising
- Settlement included 2 ½ year agreement to refrain from billing any services under the "incident to" rate, even if the services could be properly billed for under that rate

https://www.justice.gov/usao-edpa/pr/doctors-and-medical-facilities-lehigh-valley-pay-690441-resolve-healthcare-fraud

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Takeaways: Appropriate Coding and Billing

- Periodic audits are KEYS to compliance
  - Review claims to ensure correct provider and services are billed
  - Review documentation to ensure it supports billed claims
- Pay special attention to use of modifiers
  - Review claims history billed to determine modifiers used
  - Provide education of practitioners on modifier requirements with particular focus on Modifiers 25 and 59
  - Audit sample of claims billed with modifiers to confirm documentation supports services billed

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Takeaways: Appropriate Coding and Billing

- Know the scope of services and required supervision for NPs and PAs providing services in your practices
  - Are they billing independently?
  - Are they billing "incident to" or "split/shared"?
- Educate physicians and NPPs on supervision requirements
- Observe operations at clinics and ask questions about NP and PA services
- If errors are found, disclose to the MACs and refund any overpayments

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Takeaways: Appropriate Coding and Billing

- "Incident to" Billing
  - "Services furnished incident to physician professional services in the physician's office"
  - Requirements
    - Physician personally performed an initial service and remains actively involved in course of treatment
    - Physician does not have to be physically present in patient's treatment room but must provide direct supervision (present in office suite to render assistance)
    - Proper documentation
  - Cannot be used for hospital services

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Takeaways: Appropriate Coding and Billing

- Split/shared services
  - "Medically necessary encounter with a patient where the physician and an NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service"
  - Substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service
  - Physician and NPP must be employed by same entity
  - Applies in hospital inpatient, outpatient or emergency room setting

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Enforcement Actions Focused on Compensation Arrangements

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Compensation Arrangement Hypothetical

- Ophthalmologist enters into consulting agreement with lens distributor and ophthalmology equipment and services company
- Consulting arrangement includes payment for travel and lodging for conferences
- Ophthalmologist did not keep time records or otherwise appear to have performed services for payment of over $100,000
- Travel was luxury travel aimed at inducing ophthalmologist to use services of lens distributor and ophthalmology equipment and services company

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Settlement – Jitendra Swarup, M.D.

- Ophthalmologist settled allegations of receiving unlawful remuneration from Precision Lens (a lens distributor), its owner, and SightPath Medical Inc. (a provider of ophthalmology equipment and services)
  - Luxury international hunting and fishing trips to induce him to use the products and services distributed by these companies
  - Above FMV compensation for consulting agreements for over $100,000 per year for services either not performed or not tracked = services considered in excess of fair market value
- Settlement involved payment of $2.9 million and 3-year corporate integrity agreement

https://www.justice.gov/usao-mn/pr/united-states-files-complaint-against-precision-lens-paul-ehlen-alleged-kickback-scheme

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Compensation Arrangement Hypothetical

- Physician signs outside agreement to serve medical director for home health agency
- Compensation as flat monthly fee of $400/month
- As part of agreement, physician signs hundreds of authorization forms stating that patients were home bound and required home health services
- Physician never sees patients

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Criminal Conviction – Warren Dailey, M.D.

- Family practice physician sentenced to 63 months in prison and ordered to pay $913,620 in restitution
- Dr. Dailey conspired with home health care owner by agreeing to sign Medicare authorization forms certifying medical necessity for unneeded home health services in exchange for flat monthly fee
- Total compensation: $9,200 over 2-year period
- Dr. Dailey signed hundreds of authorization forms for beneficiaries falsely certifying the patients were homebound, the home health was medically necessary and the beneficiaries were under his care without ever seeing the patients

https://www.justice.gov/usao-sdtx/pr/jury-convicts-doctor-home-health-care-fraud

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Compensation Arrangement Hypothetical

- Physician practice employs physicians under percentage of collections
- Physician practice performs certain labs and other diagnostic tests in the practice
- Physicians' compensation includes bonuses for direct percentage of all charges, including lab and diagnostic test revenue

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Settlement – Stephen F. Serbin, M.D. and Victoria Serbin

- Stephen F. Serbin, M.D., owner of Family Medicine Centers of South Carolina, LLC ("FMC"), and FMC's laboratory director, Victoria Serbin, paid $443,000 to resolve FCA claim based on alleged self-referral scheme
- At Dr. Serbin's direction, FMC paid employed physicians fixed base salaries and productivity bonuses "not limited to a physician's personally performed services or to non-DHS; rather, a physician who was contractually entitled to the bonus received a direct percentage of all charges billed on behalf of the physician, which included DHS payable by Medicare"
- FMC and Dr. Serbin circulated an internal document criticizing any physicians "who continue to ship much of our potential profit down the road instead of referring these services in-house [and] will, of course, receive less compensation in their Employment Agreement"

https://www.justice.gov/opa/pr/south-carolina-family-practice-chain-its-co-owner-and-its-laboratory-director-agree-pay

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Takeaway: Arrangements – Focus on the Basics

- Establish centralized contracting process for consistent review and approval of all arrangements.
- Rely on agreements meeting legal requirements.
- Confirm fair market value of arrangement.
  - Implement simple, consistent, compliant, auditable compensation.
  - Consider when outside valuations will be required.
  - DON'T forum shop opinions
  - Choose experienced, reputable valuator.
- Document appropriate business justification for arrangement.
  - DON'T pay for referrals.
- Document performance of services, including time sheets if required.

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Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability

- OIG Special Fraud Alert (June 9, 2015)
  - Compensation arrangements with **medical directors** must be fair market value for bona fide services that physicians actually provide
- Questions to ask
  - How are they selected?
  - What is communicated about how they are selected?
  - How is compensation determined?
  - How is performance tracked?
  - Is doctor paid regardless of completion of services?

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Enforcement Actions Focused on Medical Necessity

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Medical Necessity Hypothetical

- Physician performs autonomic nervous function testing on equipment within the practice
- LCD governing testing requires specific equipment to be used
- Tests used for screening and monitoring of patients' condition
- Patients not diagnosed with autonomic nervous function before testing performed
- Physician fails to spend required amount of time with patients or conduct necessary assessments

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Sureshkumar Muttah, M.D. - Settlement

- $1.526 million settlement and 3-year CIA to resolve FCA allegations of billing for medically unnecessary autonomic nervous function tests
- Physician performed tests merely to monitor symptoms and conducted screening without signs or symptoms of autonomic dysfunction
- Physician failed to:
  - Have necessary equipment to perform tests
  - Clinically diagnose patients with autonomic function disorder before testing
  - Obtain appropriate training required to conduct tests or interpret results
  - Follow LCD requirements covering indications and limitations for testing
  - Make clinical decisions or manage patient care with test results
- Physician also misrepresented services actually performed by failing to spend required amount of time with patients or conduct necessary assessments

https://www.justice.gov/usao-md/pr/united-states-reaches-settlement-riverdale-internist-resolve-false-claims-act-allegations

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Sureshkumar Muttah, M.D. - Settlement

- $1.526 million settlement and 3-year CIA to resolve FCA allegations of billing for medically unnecessary autonomic nervous function tests
- Physician performed tests merely to monitor symptoms and conducted screening without signs or symptoms of autonomic dysfunction
- Physician failed to:
  - Have necessary equipment to perform tests
  - Did not clinically diagnose patients with an autonomic function disorder before conducting tests
  - Obtain appropriate training required to conduct tests or interpret results
  - Failed to follow LCD requirements covering indications and limitations for autonomic function testing
  - Make clinical decisions or manage patient care with test results
- Physician also misrepresented services actually performed by failing to spend required amount of time with patients or conduct necessary assessments

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Medical Necessity - Third Time's the Charm or Three Strikes?

- Joseph P. Galichia M.D. and his practice paid $5.8 million to resolve allegations of improper billing for medically unnecessary cardiac stent procedures from 2008 through 2014
- In 2009, Galichia and practice paid $1.3 million to settle allegations of submitting claims for services not provided or lacking proper documentation
- In 2000, Galichia and practice paid $1.5 million to settle allegations submitting up-coded claims, double billing, and billing for services not provided
- Galichia denies any wrongdoing but settled "because fighting the action was taking up far too much of his time and energy"
- Galichia also agreed to 3--year exclusion from participation in any federal health care program

https://www.justice.gov/opa/pr/kansas-cardiologist-and-his-practice-pay-58-million-resolve-alleged-false-billings

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Takeaways: Medical Necessity

- Keep up-to-date with changing billing code and complexity requirements
- Evaluate tests and procedures to ensure appropriate equipment is available to support billing codes
- Ensure personnel have required training for performing services
- Educate practitioners on billing code requirements for performing tests
- Audit records and processes to ensure documentation and actual practices support codes billed and services are medically necessary
- When potential concerns are raised, proactively review matters and take appropriate corrective action, including refund of claims

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Enforcement Actions Focused on Other Billing Practices

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Retention of Overpayments

- ***U.S. ex rel. Hernandez-Gil v. Dental Dreams, LLC* (D.N.M. 2018)**
  - Former employee alleged defendant dental practice retained overpayments in violation of FCA
  - Management informed of billing practices but refused to allow investigation or audit
  - "[I]t would cost too much money"
  - District court denied summary judgment motion
  - Reasonable jury could infer defendant "knew it received overpayments and took no steps to investigate, quantify, report, or return overpayments"
- ***Takeaway:*** Reasonably investigate potential overpayments, even when no overpayments specifically identified

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Routine Waiver of Co-Pays and Deductibles

- ***U.S. ex rel. Abrahamsen v. Hudson Valley Hematology-Oncology Associates, R.L.L.P. (S.D.N.Y. 2016)***
- $5.31 million settlement and CIA to resolve AKS and FCA violations
- Allegation: Routinely waived copayments for E/M services that did not meet (i) financial hardship exception or (ii) exhaustion of reasonable collection efforts
- Allegation: Overbilled Medicare by including amount of waived copayment in amount billed for service
- Noted copayment waivers in billing system by terms such as "write-off," "down coding for Medicare," and "professional courtesy"
- ***Takeaway:*** Waiver of coinsurance or deductible for documented financial need or after reasonable collection efforts have failed

https://www.justice.gov/usao-sdny/press-release/file/904411/download

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Final Tips

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Final Tips

- **Develop policies and procedures to address risk areas.**
  - **Review recent settlements for potential risk areas.**
  - **Stay up to date on changing payment requirements.**
- **Provide effective training and education focused on risk areas.**
  - **Case studies and lessons learned are often effective.**
- **Foster open and effective communication.**
  - **LISTEN to and ADDRESS concerns.**
- **Conduct regular internal audits to monitor compliance with regulations and billing requirements.**
- **Timely correct problems when they are identified.**

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Questions

Anna Grizzle
agrizzle@bassberry.com

Shannone Raybon
Shannone.Raybon@carespot.com

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