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Medical Transportation Compliance

It Extends Beyond Billing

Mandated Compliance Guidance



Compliance 2011

- ▶ NY State Medicaid Office of Inspector General (OMIG) has **mandated** compliance for providers with a \$500,000 threshold of Medicaid revenue over a consecutive 12 month period.
- ▶ The Patient Protection and Affordable Care Act (PPACA) **includes mandates** for compliance programs for all providers.



Compliance 2011

New York State Medical Transportation Companies

▶ Financial Penalties:

- ❑ Linwil Transportation - \$320,000
- ❑ TYMPF - \$85,000
- ❑ Rzan Medical Transportation - \$643,000
- ❑ Metropolitan Ambulance and First Aid, (SEZ Metro Corp.)

Metro North Ambulance Corp., Big Apple Ambulance

All owned by one individual, \$2.85 million penalty for appealing a Medicare decision with falsified documents.

Compliance 2011

- ▶ Federal Activity:
- ▶ Rural Metro – \$2.5 million for violating the Anti-kickback Statute and Billing for Services NOT Medically Necessary
 - Corporate Integrity Agreement
 - Whistleblower and DOJ lawsuit
 - – FBI Investigation
 - – Another Corporate Integrity Agreement – OHIO

Compliance 2011

- ▶ List of Sanctions Providers may incur:
 - Financial Penalties
 - Exclusion from Medicaid and Medicare participation
 - Criminal Charges which can include employees
 - Loss of licensure
 - Corporate Integrity Agreement (CIA) which is government involvement in your company for a period of years (avg 5 years, can be more) PLUS the provider must hire outside consultants to oversee and report back to the government

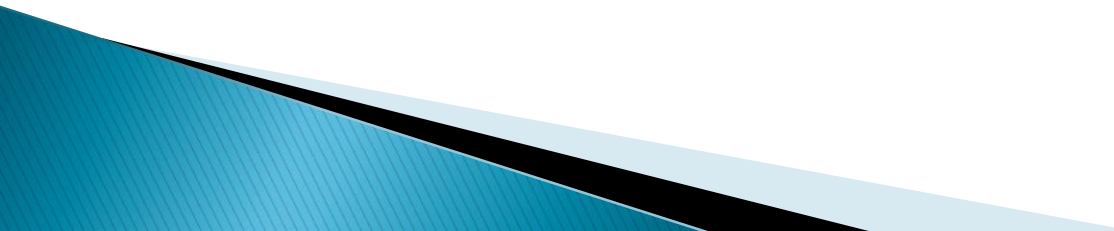


Compliance 2011

- ▶ What happened to these companies?
They were not operating with a compliance program that met the requirements both state and federal.
- ▶ Could they have avoided these sanctions?
- ▶ YES
- ▶ How?



Compliance 2011

- ▶ If you are billing Medicaid and Medicare, YOU MUST be in compliance according to the regulations and laws established.
 - ▶ Your organization is a business and must be operated as a business.
 - ▶ Compliance is a priority.
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Compliance 2011

- ▶ Both New York State and the Federal Government have published laws and regulations governing health care compliance
- ▶ Providers must make compliance a priority and ensure that the required elements are implemented on a day to day basis.



Compliance 2011

- ▶ The New York mandated requirements were established by the New York Office of Medicaid Inspector General (OMIG) and became effective September 29, 2009.
- ▶ Social Service Law 363-d(Chapter 442 Laws of NYS)
- ▶ Expanded Risk Areas : Billing
Governance
Credentialing
Medical Necessity
Quality of Care

And all “other risk areas that are or should with due diligence be identified by the provider” (OMIG)



Compliance 2011

- ▶ Providers with a Medicaid revenue threshold of \$500,000 in the last 12 consecutive months must certify to NY OMIG every December that they have an effective compliance program



Compliance 2011

- ▶ Requirements of an “effective” compliance program include 8 Elements and an emphasis on Fraud, Waste and Abuse

The 8 Elements (NYS OMIG 18 NYCRR Part 521)

1. Written Compliance Plan and Code of Conduct
2. Designation of a Compliance Officer
3. Training and Education
4. Communication
5. Disciplinary Policies
6. Auditing and Monitoring
7. Response, Reporting and Refunding
8. Non-intimidation and Non-retaliation



Compliance 2011

- ▶ 1. The written compliance plan and code of conduct that describes compliance expectations
- ▶ 2. Designation of a Compliance Officer responsible for the day to day operation of the compliance program who reports to the CEO or other senior member of management (except the CFO) and who reports to the Governing Board periodically



Compliance 2011

- ▶ 3. Training and Education must be conducted for employees including executives and governing board members and business agents regarding compliance expectations. Training should occur at a minimum annually and upon new hire orientation.
- ▶ Training should also include how to identify non-compliant activities and fraud, waste and/or abuse.



Compliance 2011

- ▶ 4. The Compliance Officer must be accessible to all employees and there must be a mechanism for anonymous and confidential reporting (i.e. hotline number)
- ▶ 5. Consistent Disciplinary policies must be in place to encourage good faith participation in the compliance program, which must be clear and include participation in non-compliance behavior and failure to report suspected problems as grounds for discipline



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- ▶ 6. Auditing and Monitoring is the mechanism for “routine identification of compliance risk areas” and implementation of internal and external audits for evaluation of non-compliance
- ▶ Note: Key area of the compliance elements.
- ▶ The documented audits and monitoring of identified risk areas is your proof to government auditors that your organization is actively involved in maintaining a culture of compliance and are following the requirements set forth



Compliance 2011

Audit schedules will include results from:
The analysis of the risk assessment
Focus items detailed in the OIG work plan
Focus items detailed in the OMIG work plan
Prior audits of medical transportation providers



Compliance 2011

- ▶ 7. Response to suspected compliance violations and/or Fraud, Waste and Abuse must occur as the issues are reported to the organization via the Compliance Officer, management, hotline etc. AND for reporting the issues to the appropriate government agency if required.
- ▶ Included in the reporting requirements must be a mechanism for reporting overpayments.



Compliance 2011

- ▶ 8. A policy for non-intimidation and non-retaliation for good faith participation in the compliance program.



Compliance 2011

- ▶ Code of Conduct
- ▶ Everyone must make a commitment to ethical behavior
- ▶ Respect for the patient and each other
- ▶ Business is conducted with absolute integrity
- ▶ Employees and Management all have responsibility to adhere to state and federal regulations



Compliance 2011

- ▶ Who is driving the compliance program to success?
- ▶ The Ambulance Governing Board is responsible for implementing the compliance program. The success of the compliance program's effectiveness requires dedicated resources and the support of the Governing Board.
- ▶ Compliance includes everyone.



Compliance 2011

- ▶ **Fraud, Waste and Abuse**
 - ▶ Inefficiency = **Waste**
 - ▶ Bending the Rules = **Abuse**
 - ▶ Intentional Deception = **Fraud**



Compliance 2011

- ▶ **Fraud** – any Intentional act or omission designed to deceive patients or the government as payor, resulting in the patients or government suffering a loss and/or the perpetrator achieving a gain.
- ▶ The most common examples of fraud include:
 - ▶ overbilling for services rendered
 - ▶ billing for services not rendered
 - ▶ falsifying documentation either to cover up billing errors or simply to complete filing requirements when carelessness resulted in the information not initially being completed



Compliance 2011

- ▶ **Waste** – the careless expenditure, consumption, mismanagement or use of resources, whether intentional or unintentional, resulting in charge to patients or the government.
- ▶ The most common example of waste includes:
- ▶ use of supplies or rendering of services that were not necessary. It should be noted that upon audit the government views the use of supplies or rendering of services for which medical necessity was not clearly documented as waste.
- ▶ Inefficiency

Compliance 2011

- ▶ **Abuse** – mistreatment of patients or destructive misuse or diversion of assets and resources, and activities that are inconsistent with sound medical or professional practices.
- ▶ The most common examples of abuse are:
 - ▶ physical or mental mistreatment of patients
 - ▶ providing substandard or inferior care or treatment of patients
 - ▶ billing for substandard care or services
 - ▶ waste to such a scale that it is more than careless
 - ▶ and destruction or acts which shorten the useful life of equipment used by the provider
- ▶ *Not following protocol– Bending the Rules*

Compliance 2011

OMIG has identified Focus Items to audit:

- ▶ Not Medically Necessary
- ▶ 90 Day exception codes – July 1, 2003 – December 31, 2005
- ▶ Services billed when patient is an inpatient
- ▶ Non-emergency ambulance services
- ▶ Documentation review with particular focus on provider's compliance programs.

- ▶ **However audits have begun for the sole purpose of ensuring providers have an “effective” compliance program.**

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- ▶ Risk Assessments

Annual processes to review internal practices against regulatory requirements to ensure compliance. The annual risk assessments include HIPAA and HITECH.

Compliance 2011

- ▶ False Claims Act 31 U.S.C. 3729 et seq
Prohibits conduct “knowingly” present or caused to be presented a false claim

Penalty –Treble damages plus penalty of \$5,500 to \$11,000 per claim

Whistleblower rewards and protections

Compliance 2011

- ▶ Fraud Enforcement and Recovery Act of 2009
FERA
 - Primary goal is to increase government recoveries
 - Provides more money for enforcement initiatives to the FBI and DOJ
 - Applicable to conduct occurring after May 20, 2009

Compliance 2011

- ▶ Expansion to FERA:
- ▶ Retaining Overpayments – “knowingly” conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

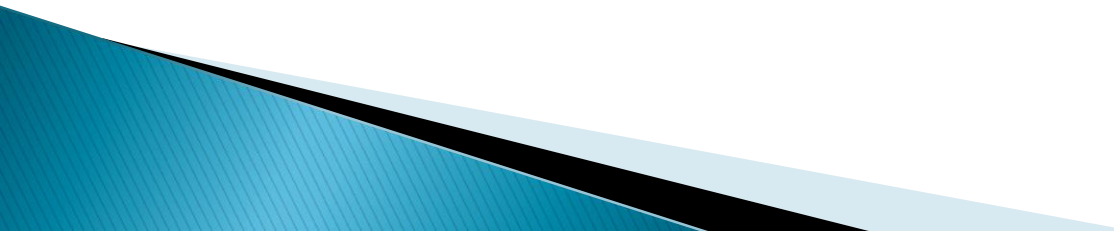
The money is not yours, never was.

Stay on top of the receivables so you will identify an overpayment as it occurs. This is not a billing service responsibility.

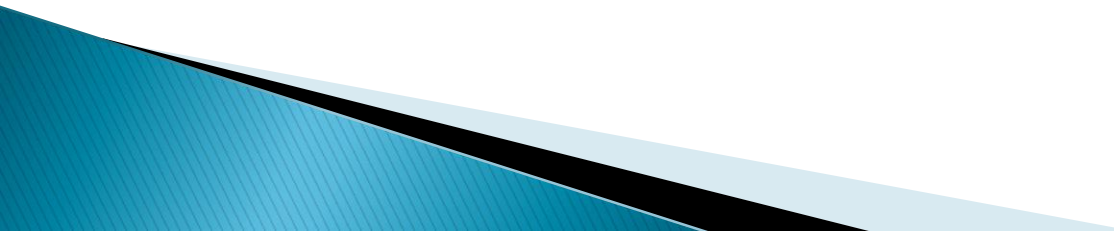
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- ▶ Third Party Billing -
- ▶ Service companies are not the answer for your compliance efforts. Providers will be held responsible for their own services, documentation, audits, billing and overpayments and all other activity that “causes” a claim to be submitted per the false Claims Act.

Compliance 2011

- ▶ Third Party Billing con't
 - ▶ What does this mean for you as the provider?
 - ▶ Review the compliance plan and training activity of your billing service.
 - ▶ Be sure that they are operating with an effective compliance program.
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- ▶ You must review PCR's before they are transmitted to the billing company.
 - ▶ Transports are medically necessary when other means of transportation are contraindicated whether or not available.
 - ▶ Does the PCR paint a clear picture of the situation at the scene?
 - ▶ Will it stand the test of time?
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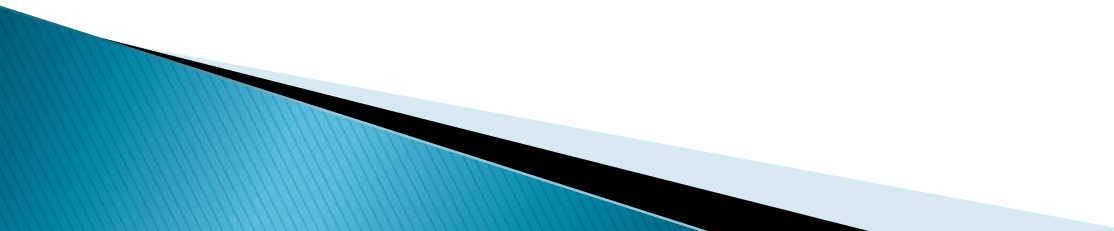
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- ▶ Medicare audited medical transportation claims for 2007 billed as emergency.
- ▶ Two-Thirds were not medically necessary !

Compliance 2011

- ▶ You are responsible for what you are providing to the billing company as billable transports.
- ▶ 18 NYCRR 504.9(b)
- ▶ “Service bureaus must maintain a system approved by the Department for notifying providers of the claims to be submitted in their behalf. **Prior to submission to the Department, claim submissions must be reviewed by the provider....** In order that a provider may correct any inaccurate claims, delete improper claims, or otherwise revise the intended submission to ensure that only claims for services actually provided, due and owing are submitted.”

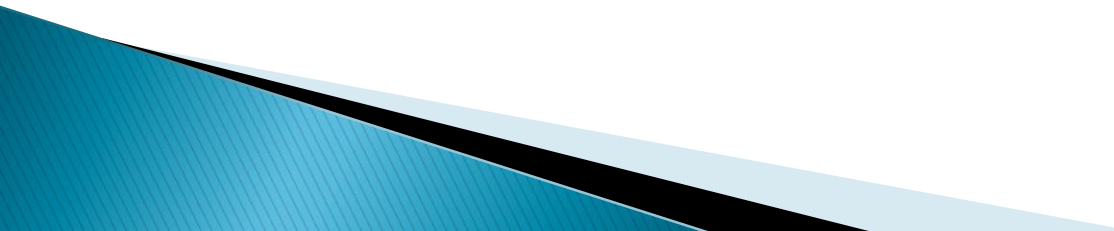
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- ▶ Provider: Who is it that is responsible for accuracy of claims submitted by third party billers?
 - ▶ “Client shall bear sole responsibility for the accuracy and proper transmission of any and all information it provides...and for errors made by the client or representative of client or errors resulting from information provided by client that results in billing errors”.
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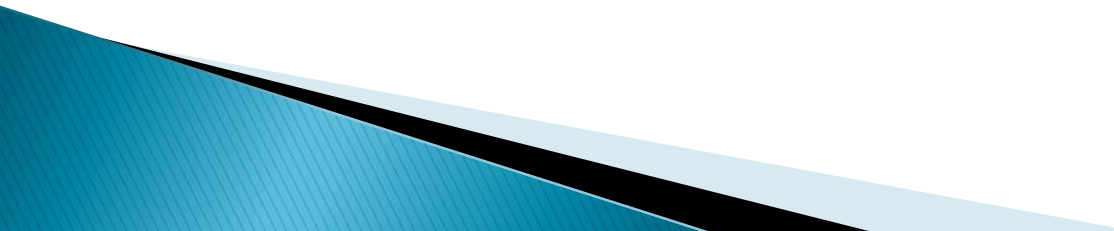
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- ▶ NY Medicaid limits on payments to a billing or collection entity *42CFR 447.10*
- ▶ Business agents. Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—
- ▶ Not dependent upon the collection of the payment.
- ▶ Not related on a percentage or other basis to the amount that is billed or collected
- ▶ Related to the cost of processing the billing

Compliance 2011

- ▶ Does the contract with the billing service provider include “written representation that the entity (third party biller) has a records preservation policy consistent with EMEDNY- 414601”
 - ▶ Does the contract with the billing service provider include written representation that they are in compliance with the “prohibition against assigning or subletting their contract” set forth in EMEDNY- 414601.
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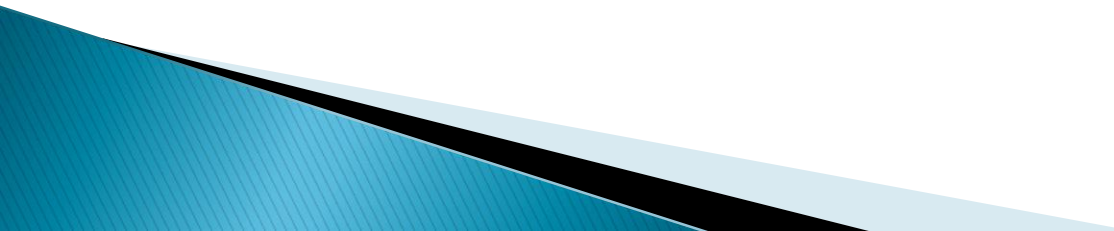
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- ▶ If any non-employee submits your claims, checks enrollment or obtains authorizations – “What documentation do they provide to you as a Medicaid provider as verification for services billed and/or submitted”?
 - ▶ EMEDNY 414801 (09/09)
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- ▶ EMEDNY-414601 (03/05)
- ▶ Maintenance of Customer records:
 - ▶ “original material and data submitted by customers for claims processing by the supplier shall be kept and maintained by the supplier in readily reviewable form and format for a period of 6 years from the date of the claims submission in order to provide the Department or other authorized agency, the ability to verify the accuracy and correctness of the claims submissions by the supplier.

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- ▶ The third party biller must assure that they comply with OIG, CMS and OMIG rules governing excluded persons.
 - ▶ The third party biller must assure that they comply with rules governing reporting, refunding and explaining identified overpayments (ACA Section 6402)
 - ▶ The third party biller must assure that they comply with rules requiring certification of an effective compliance program for entities submitting over \$500,000 per year in Medicaid claims. (18 NYCRR 521)
 - ▶ What proof do you have?
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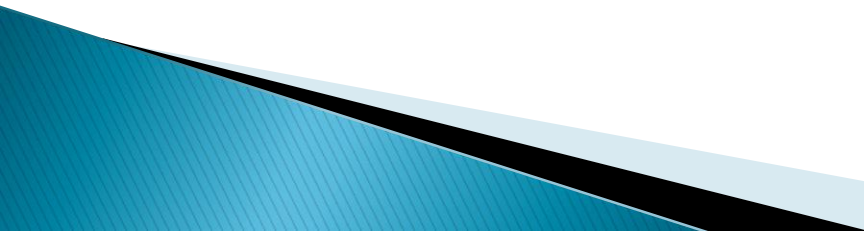
- ▶ Providers have an obligation to monitor their billing and payments. “Obligation” includes contractual, statutory and regulatory duties
- ▶ Overpayments and Self Reports:
- ▶ Auditing and monitoring could trigger the “obligation” to return an overpayment
- ▶ If you must Self Report an overpayment, (\$5,000 or greater) it must be done within 60 days of identifying it.

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Self Report Requirements

- ▶ It is now an OIG formal process
- ▶ Covers Stark and anti-kickback as well as overpayments

New York Self Reporting is significantly more expansive in scope than the federal requirement. NY includes:

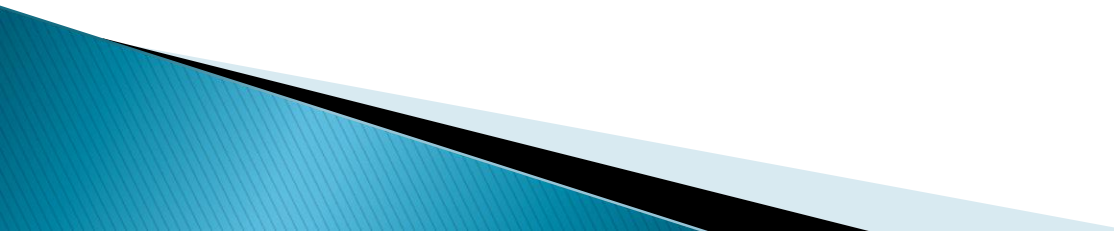
- ▶ Substantial routine errors
 - ▶ Systemic errors and patterns of errors
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- ▶ Auditing and Monitoring can prevent a routine error from becoming a substantial or systemic and/or pattern of errors.

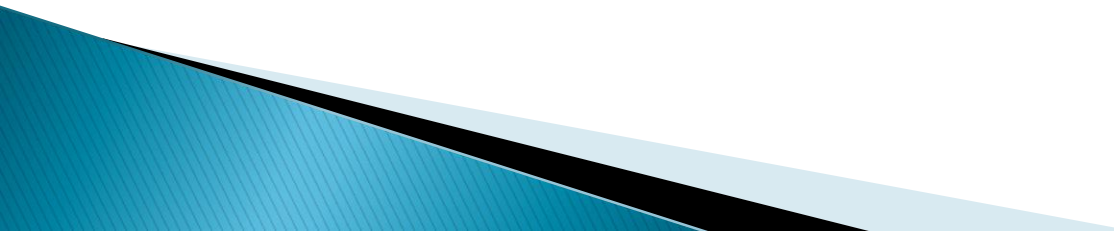
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Advantages of self-disclosure:

- ▶ Forgiveness or reduction of interest
 - ▶ Extended repayment terms—min 15% withhold
 - ▶ Waiver of penalties
 - ▶ Timely resolution of the overpayment as opposed to an audit process
 - ▶ Decreased likelihood of a corporate integrity agreement
 - ▶ May preclude whistleblower actions
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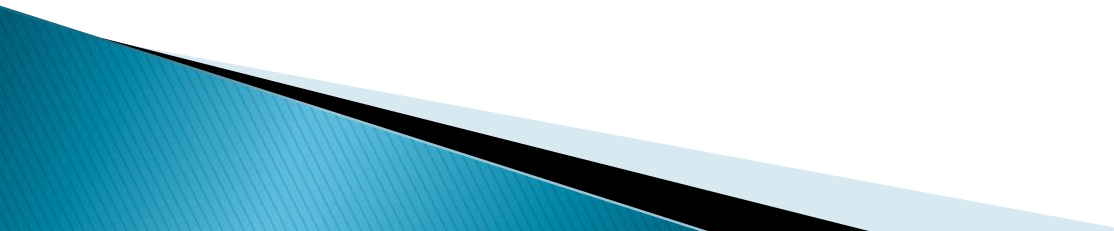
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Disadvantages of Self Disclosure:

- ▶ Invites government scrutiny
 - ▶ No guarantees
 - ▶ OMIG monitors self-disclosure issues and expands its audit program accordingly
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Compliance 2011

Key issues to consider:

- ▶ What are the available options for self disclosure?
 - ▶ What laws are implicated by the conduct at issue?
 - ▶ Is the issue systematic or isolated?
 - ▶ Does the issue involve only Medicaid, only Medicare, both, private payors?
 - ▶ What are the financial implications?
 - ▶ What corrective actions have been taken?
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Compliance 2011

Anti-Kickback Act – prevents inducements, payments or rewards for referrals of Federal health care program business including Medicare and Medicaid.

(section 1128B(b) of Act (42 U.S.C. 1320a-7b)

Penalties include possible imprisonment, criminal fines, civil monetary penalties, exclusion from government programs.

Note : A person need not have knowledge of the anti-kickback statute or specific intent to commit a violation. PPACA

Compliance 2011

- ▶ Every claim submitted based on a referral made in violation of the Anti-kickback statute will now automatically constitute a false claims violation under the False Claims Act.
- ▶ Safe Harbors – payment practices that do not violate the Anti-Kickback statute provided the payments fit squarely within a Safe Harbor.

Compliance 2011

Examples of Safe Harbors:

- ▶ Space Rental
- ▶ Equipment Rental
- ▶ Personal Services and Management Contracts
- ▶ Discounts
- ▶ Employees
- ▶ Price reductions Offered to Health Care Plans
- ▶ Shared Risk Arrangements
- ▶ Ambulance Restocking Arrangements

Compliance 2011

▶ HIPAA

Health Insurance Portability and Accountability Act

PROTECT PATIENT HEALTH INFORMATION

1. Privacy – The right of individuals to keep his/her health information from being disclosed.
2. Security – The mechanism in place to protect the privacy of health information.

Compliance 2011

- ▶ Privacy of patient health information (PHI) encompasses controlling who is:
 - authorized to access it
 - under what conditions patient information may be accessed and used
 - under what conditions patient information may be disclosed to a third party.
- ▶ *National standards exist to protect individuals medical records and other personal health information.*

Compliance 2011

- ▶ Individuals have the right to review their medical information, copy it as well as correct it.

Why would a patient want to review their medical record?

- ▶ Medical identity theft concerns
- ▶ Checking for accuracy
- ▶ To have a better understanding of their condition

Compliance 2011

Security Rule –

Controls access to PHI as well as safeguard PHI from unauthorized disclosure, alteration, loss or destruction.

The security rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic PHI.

Compliance 2011

- ▶ Administrative Safeguards- policies and procedures and disciplinary standards to ensure all personnel protect PHI.
- ▶ Physical Safeguards – Security of the company’s buildings, offices, server rooms, filing cabinets, etc.; where PHI is stored as well as your computers, workstations and electronic media.
- ▶ Technical Safeguards- Passwords, back-up and other security features on the company’s computers, networks, PDA’s, laptops, etc.

Compliance 2011

HITECH

Health Information Technology for
Economic and Clinical Health Act

- ▶ Contains incentives related to PHI technology
- ▶ Expands the protections guaranteed by HIPAA
- ▶ Increases the financial penalties for violations

Compliance 2011

HITECH protects unsecured PHI

- ▶ Requires notification in the event of a breach
- ▶ Applies a portion of HIPAA's privacy and security rules directly to business associates
- ▶ Prohibits sale of PHI without patient authorization
- ▶ If PHI is maintained in electronic format, patients have a right to receive it in electronic format.
- ▶ Strengthens enforcement mechanisms
- ▶ Patients can opt out of the use of their PHI for fundraising activities.

Compliance 2011

HIPAA – protects electronic PHI

HITECH- protects all other PHI (i.e.paper)

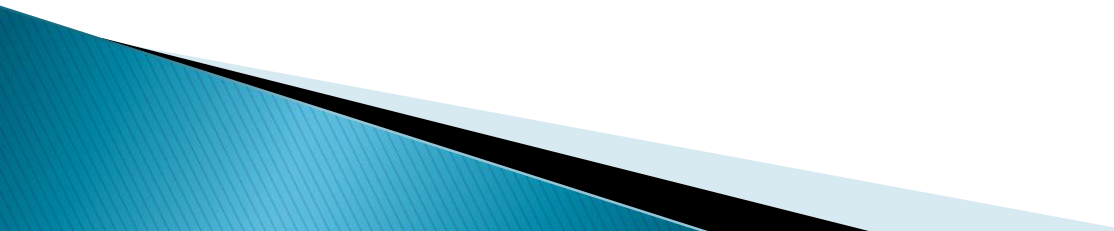
Compliance 2011

HITECH requirements:

- ▶ Providers must conduct annual HIPAA privacy and security risk assessments, document audit results and take proactive steps to reduce risk of unauthorized exposure of PHI
- ▶ Conduct an incident specific post-breach risk assessment when a data breach incident occurs. The determination must be made if it is a breach that poses a significant risk of financial, reputation or other harm to the affected individuals

Compliance 2011

Compliance Hints:

- ▶ Log off the computer when not using or leaving it.
 - ▶ Turn over paperwork at your workstation if walking away.
 - ▶ Do not leave your paperwork on the copy machine
 - ▶ Do not post pictures on facebook or other social media sites of yourself with PHI
 - ▶ Do not help yourself to PHI with no apparent reason.
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Compliance 2011

Closing

- ▶ Non-compliance, fraud, waste and/or abuse can shut your organization down.
- ▶ Make sure you have an “effective” compliance program in place.
- ▶ Make sure your business associates have an “effective” program in place.
(i.e. Billing companies)

Watermark Health Care Compliance

- ▶ 716-402-1933 Ext 5
 - ▶ If you have any questions,
▶ don't hesitate to call.
 - ▶ It's that's important!
- 