Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare

In health care, we are "*blessed*" with an abundance of rules, policies, standards and laws. In Health Care Regulation in America: Complexity, Confrontation, and Compromise, **Robert I. Field**, professor of health management and policy at Drexel University School of Public Health, observes the following:

> "***Regulation shapes all aspects*** *of America's fragmented health care industry, from the flow of dollars to the communication between physicians and patients. It is the engine that translates public policy into action. While the health and lives of patients, as well as almost one-sixth of the national economy depend on its effectiveness, health care regulation in America is bewilderingly complex."*

Here are some of the most important regulations in health care that you should not only know about, but should be actively managing with a robust compliance plan.

Stark Law (Physician Self-Referral)

When: Section 1877 of the Social Security Act, also known as the physician self-referral law, is commonly referred to as the Stark Law. When enacted in 1989, it applied only to physician referrals for clinical laboratory services. In 1993 and 1994, Congress expanded the prohibition to the additional designated health services listed below.

What: Stark Law “prohibits physicians from making referrals for designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies,” according to the Centers of Medicare & Medicaid Services (CMS). Specifically covered designated health services include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Penalties: Penalties for violating the Stark Law include denial of payment, refund of payment, imposition of a $15,000 per service civil monetary penalty, and imposition of a $100,000 civil monetary penalty for each arrangement considered to be a circumvention scheme.

The following will help you ***remain compliant with the Stark Law****:*

1. Offer all patients a written list of choices for obtaining the care your physicians are recommending.

2. Disclose any financial relationship with any entity that is on the list offered to patients.

False Claims Act

When: Originally enacted during the Civil War, and sometimes known as the Lincoln Law, the False Claims Act (FCA) as we know it today was signed by President Reagan in 1986.

What: Under the FCA, those who knowingly submit – or cause another person or entity to submit – false claims for payment of government funds will be subject to liability. The FCA contains qui tam, or "whistleblower," provisions.

Penalties: Medicare and Medicaid fraud and abuse prohibit the knowing and willful making of a false statement that affects reimbursement under a federal health program. That provision imposes felony penalties of up to five years' imprisonment and/or fines up to $250,000 for an individual and $500,000 for an organization.

In addition to criminal penalties, the Office of Inspector General (OIG) may impose civil penalties under the Civil Monetary Penalties Act for submitting false claims. Civil penalties can be up to $11,000, plus three times the amount claimed. According to the Telehealth Resource Center, "The Civil Monetary Claims Act prohibits claims for services not provided as claimed; false or fraudulent claims; claims for physician services not furnished by physicians; or claims for services provided by an excluded physician or provider. The False Claims Act gives the federal government, as well as any person, a cause of action against any person who submits false claims to the government."

*To help your practice **remain compliant with the False Claims Act**, keep the following in mind:*

1. Perform background checks and obtain references on all potential employees, making sure they are not sanctioned by the OIG.

2. Have an audit performed by a third-party biannually to make

sure that your billing department is following your compliance policy to the letter.

Anti-Kickback Statute

When: Congress enacted the anti-kickback statute, 42 U.S.C. § 1320a-7b(b), in 1977 as a prohibition against the payment of kickbacks in any form.

What: The anti-kickback statute states that criminal penalties will be issued for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration intended to induce or reward referral of business reimbursable under any of the federal health care programs (Medicare, Medicaid, etc.)

Penalties: The anti-kickback statute is a criminal statute, the violation of which constitutes a felony punishable by a fine of not more than $25,000 per offense and/or imprisonment for up to five years. A conviction also will lead to mandatory exclusion from participation in federal health care programs. The OIG also may impose civil monetary penalties of up to $50,000 for each violation, plus damages of three times the amount of the remuneration.

*To help you **remain compliant the anti-kickback statute**:*

1. Seek the advice of an experienced health care attorney before entering into any agreements with parties to pay or receive payment for goods or services where a kickback might be construed.

2. Make sure your compliance plan addresses the acceptance of gifts by physicians and staff.

Put It All Together: Your Compliance Plan

A compliance plan does not have to be long or overly complex. The federal government recommends a **seven-component compliance plan** that covers the critical points in a simple and easy-to-understand way:

1. **Designate a compliance officer**, which can be the manager or a staff member.

2. **Implement compliance and practice standards**, and have all employees sign an agreement to comply with the standards. Make compliance training a part of new employee orientation and conduct annual re-training for all staff.

3. **Conduct initial compliance training** and education for physician and staff. Training can be outsourced, and is also available online. Document all training.

4. **Oversee internal monitoring and auditing**, and document the results.

5. **Respond appropriately to detected offenses** and develop corrective action plans. Document offenses and responses.

6. **Develop open lines of communication** and encourage employees to discuss compliance at staff meetings, or in one-on-one meetings.

7. **Enforce disciplinary standards** through well-publicized guidelines.

Make sure that your compliance plan is not just a binder on the shelf! *All employees must understand the seriousness of the penalties (There are lots of examples online to illustrate this.) and the importance of compliance to the success of your practice.*

Common Sense Billing and Coding Compliance

Compliance can be a little tricky to define, but in the context of health care billing and coding, compliance is all about what we don’t do, rather than what we do. Here are 16 common sense and simply-worded rules:

1. Don’t bill what wasn’t documented.

2. Don’t bill what wasn’t done, thinking it probably was or will be.

3. Don’t provide unnecessary services.

4. Don’t name someone in the medical record or on the claim who wasn’t there.

5. Don’t double bill the payer.

6. Don’t change the place of service to maximize payment.

7. Don’t unbundle services that are part of a single service.

8. Don’t charge for related services during the global period.

9. Don’t upcode or downcode services.

10. Don’t neglect or misuse modifiers that would change the payment.

11. Don’t discount care to patients for referring other patients.

12. Don’t waive patient balances unless a financial need is documented.

13. Don’t keep the money if a patient or payer overpays.

14. Don’t change the diagnosis to achieve payment if the payer denies payment based on the diagnosis.

15. Don’t accept money or gifts to prescribe drugs, refer patients, or order procedures or tests.

16. Don’t direct patients to the facility that you own for a necessary test or procedure without disclosing that you own part or all of the facility.

Do you have any compliance tips, guidelines, or maxims that help keep your group on track? Share them in the comments below!