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Compliance Today - December 2023

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Practical mini-compliance risk assessment

by Catherine Boerner

What should you really want to feel comfortable about in terms of risk? I often think about this in practical terms. We don't have a lot of time and don't want to waste time or money. I decided to look at what recent enforcement actions can tell us. Below are some areas to consider when performing this exercise for your organization and providing education on compliance risk:

- The hospital provided the services of hospital-employed, midlevel practitioners to 13 physicians at no cost or below fair market value in violation of the Anti-Kickback Statute.
- The company presented claims to Medicare Part B for ambulance transportation to and from skilled nursing facilities (SNFs), where the SNF consolidated billing payment under Medicare Part A already covered such transportation.
- The U.S. Department of Health and Human Services Office of Inspector General (OIG) alleged that the hospital employed an individual they knew or should have known was excluded from participation in federal health care programs.
- The government alleges that Federally Qualified Health Center (FQHC) submitted false claims to Medicaid for dual-eligible beneficiaries with the incorrect Medicare denial codes. This caused Medicaid to pay claims it would have otherwise denied. The government also alleges that FQHC improperly billed Medicaid for group therapy services for Qualified Medicare Beneficiaries who were not eligible for reimbursement for those services.
- Inflated office "rental payments" and fees paid to contracted cardiologists. Office space rental agreements, often above fair market value, with primary care and other physicians (or their medical practices) to induce these physicians to refer patients to Group A: contracted cardiologists who saw patients at the rented office space. These cardiologists (Group A) then regularly ordered diagnostic tests and procedures performed at locations and were paid a flat fee for each referral.
- OIG alleged that hospice submitted claims for services provided by two unlicensed nurses.
- The U.S. alleged that a Medicare Advantage plan engaged in chart reviews of their Medicare Advantage beneficiaries to identify additional diagnosis codes that had not been submitted to Medicare. However, many of the additional codes submitted were not properly supported by the patient's medical records. The government alleged that the Medicare Advantage plan nevertheless submitted those diagnosis codes, which resulted in higher payments from the Centers for Medicare & Medicaid Services.