

# **“Just Say No!” Avoiding Addiction Treatment Fraud and Abuse: What You Need to Know to Get and Stay in Compliance**

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## **Content to be covered:**

1. **What is “Fraud and Abuse”?**
  - a) Defining the terms
  - b) Common issues
2. **Hot Topics and Trends in Fraud and Abuse Enforcement**
  - a) “Step-Down Billing”
  - b) Marketing/Kick-Back Issues
  - c) Patient Financial Responsibility
  - d) Abusive Procurement of Insurance
  - e) Urine Testing
3. **Strategies for Responding to Audits & Investigations**
  - a) Different Types of Encounters
  - b) Investigation checklist
4. **Questions?**

OVERVIEW



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## 1. What is “Fraud and Abuse”?



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## Recent Enforcement Trends

- Growing number of large payors (Anthem, Blue Shield, Health Net, Aetna, Cigna, United) alleging fraud and abuse
  - Targeting behavioral healthcare facilities
  - Special Investigations Unit (SIU) investigations and task forces
  - Recoupment of fees
  - Referrals to State licensing agencies and criminal prosecutors

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## Why does this matter?

- For years, addiction treatment was overwhelmingly cash-pay and marketing was largely ignored by regulators
- The post-ACA explosive growth of the industry has shined a spotlight on marketing abuses
  - Attention to insurance claims growth and fraud concerns
  - Attention to patient safety issues
  - DHCS, Department of Insurance playing catchup
  - California legislature under pressure to tighten laws
  - Growing number of large payor (Anthem, Blue Shied, Health Net, Aetna, Cigna, United) Special Investigations Unit (SIU) investigations, task forces, referrals to criminal prosecutors

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**Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

**Abuse:** provider practices that are inconsistent with sound business or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for care.



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## False Claims

- Insurance companies argue that provider claims tainted by fraud and abuse are “false” claims
- State False Claims Laws–prohibit the preparation and/or submission of false claims for payment to private insurers.
- Federal False Claims Act –prohibit false claims made to the Federal Government (Medicare/Medicaid)
- Lawsuits initiated by “whistleblowers,” who have financial incentive to report health care fraud – and are entitled to a portion of any recovery.



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## Practices that Raise the Risk of Claims of Fraud and Abuse

- a) “Step-Down Billing”
- b) Marketing/Kick-Back Issues
- c) Patient Financial Responsibility
- d) Abusive Procurement of Insurance
- e) Urine Drug Testing

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## The End of “Step-Down” Billing



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## Step-Down Billing (or Down-Coding) is often Denied by Payors

- The codes you include on your bills are a “representation” of the services you provide.
- Coding for a lower level of treatment than what you provide still “misrepresents” the work you have done
  - Even though it may seem like a windfall for the payor
- Bottom line:  
**YOU MUST PERFORM THE EXACT SERVICES FOR WHICH  
 YOU BILL THE INSURANCE COMPANY!**

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## Kickbacks and Self-Referrals



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## Key Terms

- ✘ **Kickback:** giving or receiving anything of value to induce referrals of patients, goods, and services
- ✘ **Self-Referral:** referring a patient for goods or services in which the physician or family member has a financial interest
- ✘ **Capping/Steering:** paying marketers to recruit patients on a per patient basis or based on value/volume of recruitment



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## Example: California Insurance Code Section 750

- “[A]ny person acting individually or through his or her employees or agents, who engages in the practice of processing, presenting, or negotiating claims, including claims under policies of insurance, and who **offers, delivers, receives, or accepts any rebate, refund, commission, or other consideration**, whether in the form of money or otherwise, as **compensation or inducement to or from any person for the referral or procurement of clients**, cases, patients, or customers, is guilty of a crime.”
- Punishable by imprisonment and/or a fine up to \$50k.
- No specific intent to violate the law; government need only prove that you offered or accepted consideration for the inducement of referrals.
  - *People v. Hering*, 20 Cal.4<sup>th</sup> 440 (1999)
  - *People v. Guimelon*, 205 Cal.App.4<sup>th</sup> 383 (2012)

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## Bed Vouchers

- Kickbacks are not limited to payment of cash for referrals.
- Quid pro quo arrangements with sober livings to pay for “bed vouchers” in exchange for referrals to outpatient treatment, are a problem.
  - See, e.g., <http://www.dcourier.com/news/2016/may/31/claims-insurance-fraud-lead-scrutiny-group-home-in/>
  - Who is paying “fair market value” for what?



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## Florida's new "Practices of SAS Providers Act"



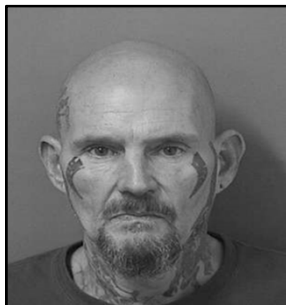
- Criminalizes deceptive marketing practices by service provider, recovery residence operator, or advertiser/marketer
  - Criminalizes misleading info re: identity, products, goods, services, or location of licensed provider
- Expands prohibition on any benefit to induce patient referral
- Enhanced penalties for higher volume of patient brokering
- New licensing of substance abuse marketing services
- Prohibits referrals by uncertified sober home to licensed provider

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## Enforcement



John Dudek, charged with receiving kickbacks from a drug treatment center for brokering patients from his sober home.

Source: Palm Beach Post, Nov. 19, 2016

<http://www.mypalmbeachpost.com/news/news/crime-law/third-sober-home-official-arrested-on-patient-brok/ntBQm/>

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## Understanding What Is Legal in Hiring Marketers

- ***Paying for Services versus Referrals***
  - Paying **fair market price** for the time, skill, and effort involved **is OK**.
  - Paying per successful referral is **not OK**.
  - Written contract with commercially reasonable terms, for a term of one year or more, not affected by referral value/volume is preferred.
  - Try to specify services in contract.
- ***Marketing Personnel as W-2 Employees versus 1099***
  - Classification depends on IRS criteria, not a matter of choice
  - “Economic realities test”
    - (1) “control” over the worker, as to “work done” and
    - (2) “manner and means” in which it is performed



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## Call Centers

- Treatment programs can operate their own call centers but there are many pitfalls!
- Paying outside call centers a flat (hourly) rate, irrespective of # of leads **is OK**
- Paying for # of **un**qualified leads – without a success fee – **is probably OK**
- Paying for qualified leads without a success fee **is less OK**
- Paying any kind of success fee **is not OK**



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## Patient Financial Responsibility



"Good news. Your HMO says you're feeling fine."

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## Understanding Insurers' Position

Insurance companies argue that providers who waive or discount patient fees have no right to be paid under policy, and are committing fraud and abuse:

- Potential inducement of patient to attend program because a patient may choose a provider who waives/discounts fees over other providers.
- Misstatement of reasonable and customary fees and interference with contract between patient and insurance company.
- Form of deception because provider charges different rates to different payors.
- Fraud argument has been around for decades, but in last 5 to 6 years we have seen aggressive enforcement.

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## What is cost-sharing?

Deductible

Copay

Coinsurance

Balance of Fee

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## Medicare's Long-Standing Prohibition Against Fee Waivers

- Federal Anti-Kickback Statute and Civil Money Penalties Law prohibit providers from **routinely** waiving Medicare or Medicaid beneficiaries' copayments and deductibles.
- Waiver functions as a "kickback" or "inducement" to beneficiaries to encourage them to obtain services, even unnecessary services.

"A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is \$100, but routinely waives the copayment, the actual charge is \$80. Medicare should be paying 80 percent of \$80 (or \$64), rather than 80 percent of \$100 (or \$80). As a result of the supplier's **misrepresentation**, the Medicare program is paying \$16 more than it should for this item."

Department of Health & Human Services, Office of Inspector General: Special Fraud Alert, December 19, 1994

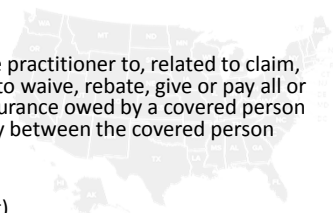
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## Fee waivers expressly prohibited in some states

- Florida
  - Fla. Stat. § 817.234(7) – prohibits any service provider, other than a hospital, from billing amounts as the provider's usual and customary charge if the provider has agreed with the insured "to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge."
- Colorado
  - Colo. Rev. Stat. § 18-13-119(3) – prohibits the regular business practice of submitting a claim with the prior understanding or agreement to waive the copayment or deductible, or accept the amount the insurer covers as payment in full for services rendered
- New Jersey?
  - AB 2984 – makes it a crime for a health care practitioner to, related to claim, knowingly waive, rebate, give, pay, or offer to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of an insurance policy between the covered person and that person's insurance company
- California?
  - Aetna v. Bay Area Surgical (2016 jury verdict)



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## Practices that raise risk

- ***Routinely*** offering discounts on fees to all patients
- ***Routinely*** waiving deductibles, copays, and coinsurance



- Charging of inconsistent rates to different payors for treatment services
- Insufficient documentation

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## When can programs reduce fees?

Financial  
Hardship

Prompt  
Payment



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## Financial Hardship Waiver

- If you choose to take the risk, best approach is at least do so in an arguably defensible way. The hardship waiver should:
  - Never be part of any advertisement or solicitation.
  - Not be routine.
  - Be offered only after making a good-faith determination that the patient is in financial need.



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## Financial Hardship Waivers (cont.)

Financial hardship waivers or “scholarship” programs will raise red flags if:

- Advertised
- Promised as part of a referral process
- Charges increased to offset waivers or discounts
- Failure to collect or attempt to collect from specific group of insureds for reasons unrelated to financial hardship (e.g., financial hardship waivers or scholarships given to all patients from a particular referral source)



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## Financial Hardship Waivers Sample Form

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

### 2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,940
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972

Please provide following information so we may complete your application:

- ☐ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- ☐ Check stubs for the past 30 days for all persons employed in the home.
- ☐ Unemployment check stubs for the past 30 days.
- ☐ Drivers license or identification card for adults.
- ☐ Proof of all other income received in the past 30 days.
- ☐ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- ☐ DSHS Denial letter.
- ☐ Medicaid forms or card
- ☐ Attached financial statement (completely filled out and signed)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed!

Please return all items (as applicable) on this checklist (in person or by mail).

Financial statement payment plan/uncompensated services application.

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## Prompt Payment Discounts (cont.)



### Best Practices for Extending Prompt Pay Discounts:

- Discount should be for “prompt payment” *after* services have been rendered
- “Prompt” payment generally means payment received within 30 days of the date of the invoice
  - Invoice itself can offer the prompt pay discount
- Based on practices in other healthcare settings, discount should be commercially reasonable
  - 5%-10% of fees?
- One relatively conservative view is that the discount should be applied to co-insurance and balance of the fee, not to the deductible

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## Strategies for Reducing Risk

- Don't market discounts
- Ensure that all agreements obligate the patient to pay for services that are not covered by insurance
- Conduct accurate benefits verifications
- Make commercially reasonable efforts to collect
- Keep a record of all payment received patient and designate what for (e.g., deductible)
- Keep a record of all invoices sent to patients and collection attempts
- Do not vary charges based on insurance
- Collect proper documentation verifying financial hardship

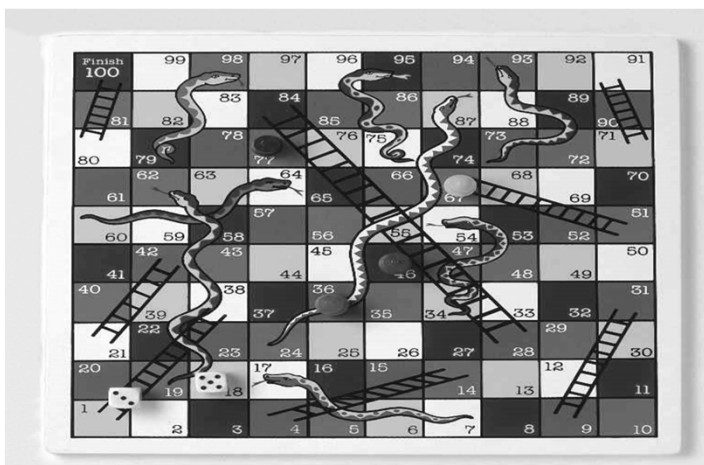


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## Abusive Procurement of Insurance



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## Crack-Down on “Gaming the System”

- Insurers have been investigating “gaming” behavior with exchange-based insurance plans:
  - Applications for insurance with a **new address** inconsistent with their previous available address data;
  - At an **address linked to an addiction treatment provider** or sober living facility;
  - With a policy **paid for by someone unrelated** who appears to lack a personal connection and insurable interest; and
  - The policy paid and maintained **only for as long as treatment is needed**.

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## Can this be a Kickback???

- Paying for insurance has been alleged by insurance companies to be a form of kickback
  - Quid pro quo to induce patients to choose the specific program
- Some providers have established non-profit “charities” to procure and pay premiums for their patients
- Then terminate the policy once treatment is finished
  - Potential IRS violation (re non-profit status)
  - Potential kick-back issue (as between non-profit and provider)
- Clever! . . . But not OK!

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## Community Recovery

- Facility enrolls new clients in insurance (allegedly without clients’ knowledge) and pays the premium
  - First 9 months of 2014, Blue Shield received at least 164 applications for insurance using Community Recovery addresses
    - And Community Recovery numbered (non-personalized) emails
  - Allegation that Facility was opening and acting on mail, forging client signatures on applications
- Insurance Companies stopped payment
- 50 counts of Fraud, grand theft, and money laundering
  - Postscript: Charged in Nov. 2016 with rape, sexual assault etc.

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## Creating a “Staffing Agency”

- One provider recently created a staffing agency and “hired” its patients
- Then set up employer-based coverage for its employees
- Then billed for care to its patient/employees under the employer-based plan
  - Clever! . . . But not OK! (actually, see Community Recovery)

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## Best Practices re: Procuring Insurance

- Not OK:
  - Procure insurance for your own patients
  - Pay premiums for your own patients
- Maybe OK
  - Direct patients to particular insurers
    - Risk appearance of quid pro quo?
- OK
  - Provide patients with information about insurance *options*

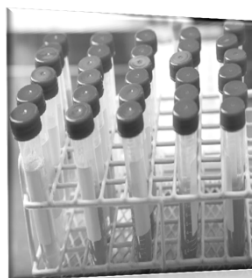
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## 6. Urine Drug Testing

- Explosive growth of UDT
- Growing law enforcement focus
- Understanding the legal issues
- Avoiding risk areas
- Using UDT appropriately



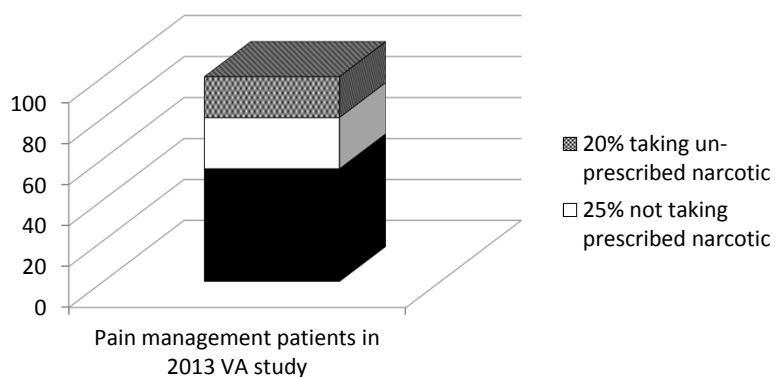
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## Explosive growth in UDT

- Growth in UDT tracks growth in narcotic opioid prescribing



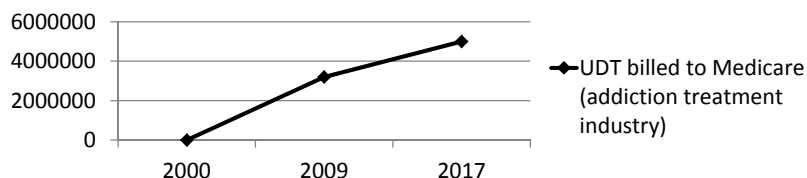
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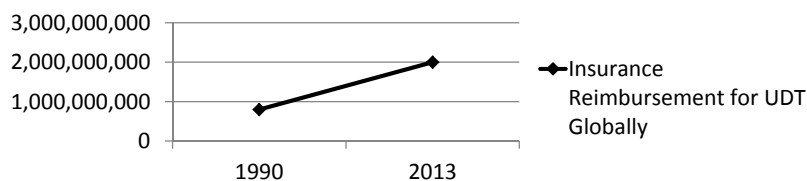
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## Explosive growth in UDT

UDT billed to Medicare (addiction treatment industry)



Insurance Reimbursement for UDT Globally



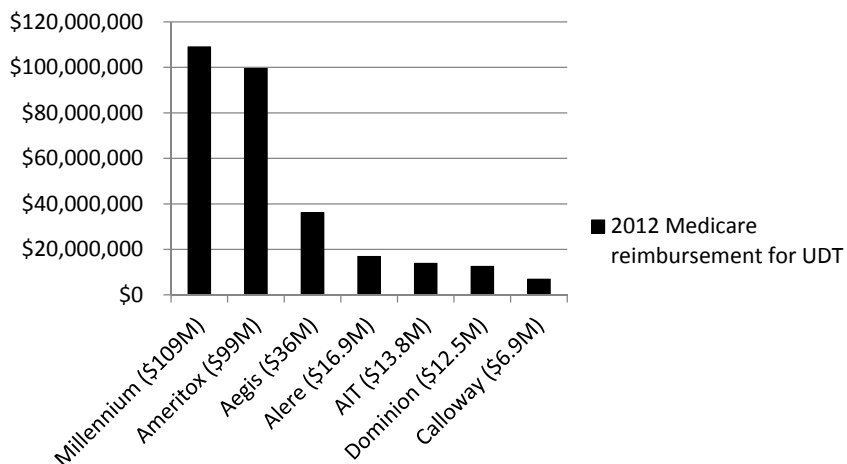
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## Explosive growth in UDT (cnt'd)

2012 Medicare reimbursement for UDT



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## What are the big UDT issues?

1. Tests not MD-ordered based on medical necessity determination
  - Be careful with “standing orders” not tailored to specific needs
  - Make sure results are reviewed and/or acted on by physician (PremierTox)
  - SAMHSA recommends “step-down” testing frequency
2. Lab not appropriately licensed and certified for tests performed
  - Labs require licensure in state of operation **and** state where patients whose samples are being tested reside
3. Labs violating anti-markup rules by marking up tests done by other labs
  - E.g., California B&P Code Section 655.5

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## What are big UDT issues? (Cnt'd)

4. Financial Kickbacks for referring lab tests
  - Labs paying referring MDs or drug treatment facilities
5. Non-financial inducements for referrals
  - E.g., point of care cups or onsite collection services
6. Physician self-referrals
  - Federal “Stark” Law and Cal. B&P 650.01 prohibit a physician from referring to a lab in which the physician or an immediate family member has a financial interest
7. Sham investment arrangements to camouflage referral arrangements
  - Making physicians/programs into “investors” to mask referral fees (e.g., Sky Tox)
  - Investment can be OK; but risky. Return must **not** be based on volume of referrals or other indicator of self-referral/kickback

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## UDT Best Practices

- **Documentation of a new patient record** should include a detailed history, appropriate physical examination, and treatment order – as MD would make with any new patient, including a signed order
- **Documentation** of periodic follow-up visits and **physician review of UDT results**, including specific analysis of the implication of relevant results (not just circling or underlying relevant data), i.e. commenting on test results and any changes in treatment – to demonstrate that they are being used in an ongoing course of care, not just a one-time visit followed by “ad infinitum” testing
- **Signed order and documentation of testing frequency** tapering down over time with randomization and focus on risky points

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## UDT Best Practices (Cont'd)

- For programs that wish to test more frequently than may be medically valuable from MD perspective, consider bifurcating between:
  - UDT that is physician-ordered and treatment-focused (and therefore reimbursable), and
  - testing that is strictly for the chemical dependency program's purposes to confirm abstinence irrespective of physician review (and therefore not reimbursable).
  - Limit insurance billing to genuinely doctor-ordered tests and charge patients directly for the deterrence and continued sobriety testing

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## Questions?



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