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# Legal Briefs

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## Fraud and abuse – Should you be concerned?

You are all probably aware that the Internal Revenue Service has certain “pet” income tax areas to which it gives special scrutiny. But, did you know that you are practicing in a fraud and abuse “pet” area also?

At the request of the Inspector General, the chief law enforcement officer of the U.S. Department of Health and Human Services (HHS), most Medicare carriers look very closely at anesthesia professionals. This is because carriers are required to review carefully anyone who receives over \$100,000 a year from Medicare. It is also because the Inspector General thinks many anesthesiologists make too much money from Medicare. Unfortunately, the net that catches the doctors can involve nurse anesthetists as well.

What can happen if your practice is investigated for fraud and abuse? Section 1877 of the Medicare Act makes it a felony to give or receive anything to induce or in return for a referral of a patient for service or items for which payment could be made under the Medicare or Medicaid programs.

The Inspector General can also impose civil monetary penalties of up to \$2,000 per item or service which the provider knows or should have known were not payable in part or in total under Medicare or Medicaid.

The earliest enforcement activities in anesthesia were all directed against anesthesiologists. More recently, serious allegations and investigations have been made against nurse anesthetists. Many of the fraud cases may well have been instigated by the actions of anesthesiologists, but if a CRNA knowingly aids or abets the scheme, he or she may be held equally responsible.

### Fraud

Some examples of the fraud cases that come to light include the following:

- Medicare is charged for services not rendered, e.g. the patient may have been admitted, but no operation ever took place;
- A physician charges for supervising CRNAs, but his passport had shown he was out of the country at the time;
- CRNAs or anesthesiologists “kick /back” part of their fees to a surgeon, hospital or surgical center administrator that specified their services;
- Upon the retirement of an anesthesiologist associated with a group of CRNA independent contractors, the group arranges for an internist 300 miles away to sign all the claim forms—the internist has never seen the hospital where the CRNAs practice.

These are all fairly obvious situations which should spell trouble to anyone.

### Abuse

The most commonly encountered situations which have been considered abusive by the Inspector General include the following:

- The physician bills as if he or she performed the entire service, but in reality only supervised one or more CRNAs;
- The physician bills for CRNA supervision, but he/she was occupied full time in another operating room;

- The physician bills for supervision, but was not present for all of the eight Medicare-required steps;
- The physician or CRNA bills for inappropriate pre-operating room or recovery room time units when only a non-anesthesia professional (RN) was present.

Several cases have developed recently which involve CRNAs who are independent contractors. Medicare does not allow a Part B physician bill for services rendered by CRNAs who are not employees. The physician can bill 30-minute time units for supervising non-employee CRNAs, but nothing more. The hospital can bill Part A for independent contractor CRNAs, but there must be a contract between the hospital and CRNA.

The line between employee and contractor is often confusing, but many carriers (and state Medicaid programs) spell out their requirements in great detail. Because there can be significant differences in reimbursement to physicians, the government is very quick to assume a conspiracy between doctor, CRNA and hospital to hide the true employment status of the CRNA. This is one area in which you should promptly seek legal advice if you are uncertain whether your arrangement fits.

Many abuse cases stem from something as seemingly innocent as incorrectly filled out claim forms. With the soon to be implemented authority to bill directly, CRNAs must become very aware of what billing clerks place on claims involving their services. The carrier

and the Federal Government take the view that if you are the provider receiving reimbursement, you are personally responsible for every entry made on the claim form.

If a *few* forms “upcode” or contain too many time units, the carrier will treat it as a mistake and demand immediate repayment. If these errors are more frequent (a “pattern”), the carrier will treat it as fraud or abuse and refer the matter to the Inspector General.

If your practice contemplates such billing, you need to ensure that you have a billing quality control system. Random claims should be compared with the hospital records to make sure that bills are accurate.

The cost of inattention can be devastating. For example, where incorrect time units are assigned consistently to 50 major heart surgeries, each incorrect charge can result in a \$2,000 fine plus a doubling of the amount of the actual overcharge. Thus, the Government could demand over \$100,000 in such a case.

Despite what your Medicare carrier may tell you, there is no such thing as a “routine” investigation. Whenever you are aware that you or your practice are being reviewed, you should seek expert advice. Early intervention with the carrier may serve to explain apparent discrepancies and avoid costly and time-consuming controversy if the carrier or the Inspector General of HHS decides that abuse is present.