Regulatory 411:

PA Practice, Compliance, and Regulatory Updates

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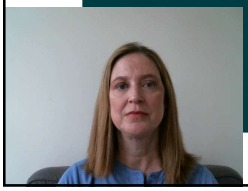
Director, Regulatory & Professional Practice
American Academy of PAs

Doctor of Health Science
Concentration: Leadership & Organizational Behavior

Graduate Certificate
Science of Healthcare Delivery

10+ Years
Regulatory and professional advocacy

15+ Years
Certified and licensed PA



AAPA

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No conflicts or financial disclosures

- This presentation and any document(s) referenced therein are for informational purposes only, and nothing therein is intended to be, or shall be construed to be as, legal or medical advice, or as a substitute for legal or medical advice. All information is being provided AS IS, and any reliance on such information is expressly at your own risk.
- This presentation was current at the time it was submitted.
- Although every reasonable effort has been made to assure the accuracy of the information herein, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The provider must ascertain payment policy and claims methodology for each payer with whom they contract.

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Objectives

- Define scope of practice and appraise determinants of scope of practice
- Describe Federal legislation and Centers for Medicare and Medicaid Services policies related to PA practice and reimbursement
- Discuss implications of fraud and abuse in healthcare

4

SCOPE OF PRACTICE

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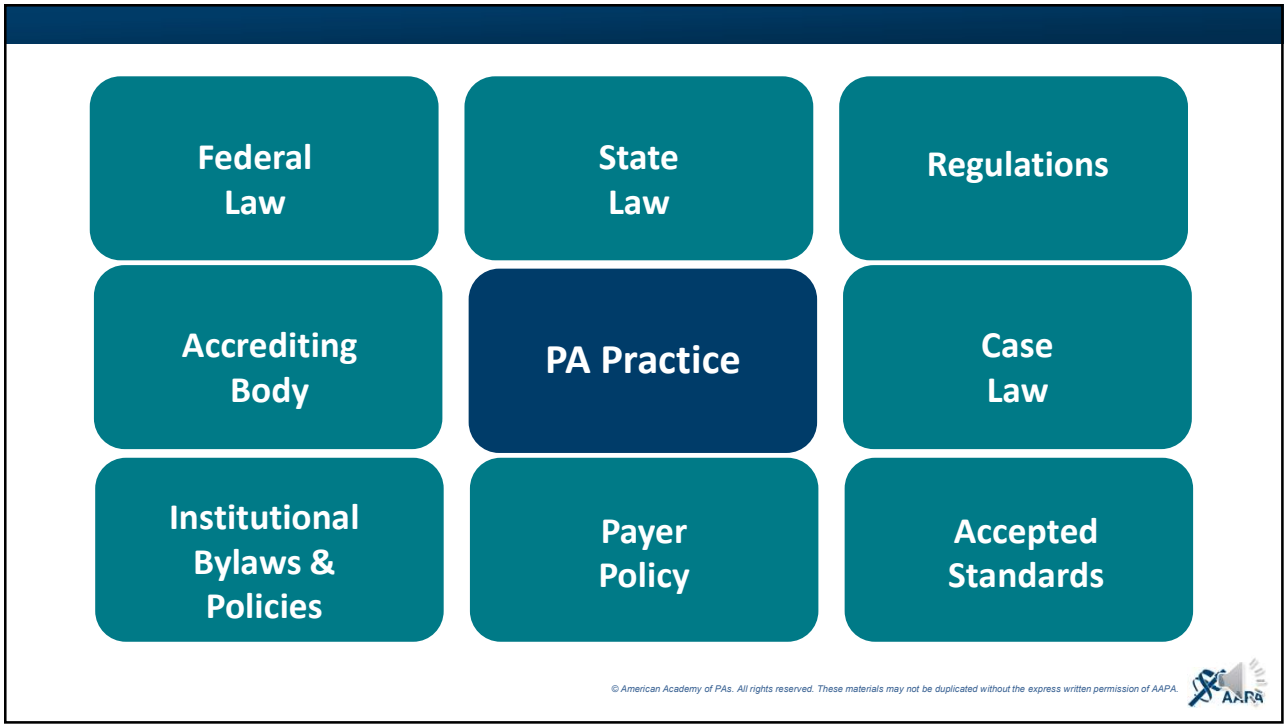

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Credentialing

process of confirming practitioner qualifications

Privileging

granted permission of services a provider may perform in hospital or facility

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Medicare Conditions of Coverage & Participation

Conditions for Coverage

- Conditions that must be met to lawfully request and receive Federal healthcare funds
- Apply to beneficiaries

Conditions of Participation

- Conditions that must be met to participate in and receive funds from a Federal health care program
- Typically relate to the quality of care provided
- May apply to non-beneficiaries

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Healthcare organizations must be certified as complying with Conditions of Participation

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Implied Certification

Submission of claim “certifies” compliance with all conditions of participation and conditions for coverage

If a healthcare provider or organization is out of compliance with a State or Federal statute, CMS regulation, or accreditation standard = basis for false claims

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The following must be met to submit a claim for Federal reimbursement

Federal Statutes & Regulation

State Statutes & Regulations

Accreditation Standards

Hospital Policies & Bylaws

Scope of Practice & Privileges

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Medicare & PAs

"If authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Medicare & PAs

Services of a PA may be covered, if all requirements are met:

- Performed by a person who meets all **PA qualifications**
- Type that are **considered physicians' services** if furnished by a doctor of medicine or osteopathy
- Are performed under the **general supervision** of an MD/DO
- Legally authorized in the state in which they are performed
- Not otherwise precluded from coverage because of a statutory exclusion

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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Examples of PA Services

New & Established Outpatient Visits
Initial & Subsequent Hospital, Discharge and Observation Services
Critical Care & Emergency Department Services
Minor Surgical Procedures and Assistant-At-Surgery Services
Diagnostic Tests and Interpretations
Chronic Care Management
Telehealth Services

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PA Qualifications

- Graduated from a physician assistant educational program that is accredited by the ARC-PA (or its predecessor agencies)
- Passed the national certification examination that is administered by NCCPA
- Be licensed by the State to practice as a PA

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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PAs

- Provide services **under general supervision** of a physician
- May bill under own name/NPI
- Reimbursed at 85%
- PAs **may not receive direct payment** (PAs employer listed in payment field)

NPs

- Provide services **in collaboration** with a physician
- May bill under own name/NPI
- Reimbursed at 85%
- May receive direct payment
- **Most NPs reassign payment as a condition of employment**

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PA Direct Pay Bill (S. 596 / H.R. 1052)

Inability to receive direct pay adversely affects PAs:

- Practicing in certified rural health clinics
- Working in a medical group that contracts with a hospital
- Wanting to own their own clinic

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Regulatory Updates

(and Reminders)

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General Supervision

"The physician supervisor (or physician designee) **need not be physically present** with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise."

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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When State law does not require "supervision"…

- > 10 states and the District of Columbia use terms other than supervision
  - Several states use "collaboration"
  - Michigan uses "participating physician"
- At least one state (North Dakota) has no defined relationship between a PA and physician
- Medicare has new policy that largely defers to state law on how PAs practice with physicians and other members of the health care team

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When State law does not require "supervision"…

"We believe that, in the absence of state law, if there is documentation at the practice which demonstrates the working relationship that PAs have with physicians in furnishing their professional services, then this would be adequate to ensure that the statutory requirement for PA physician supervision is met."

Federal Register / Vol. 84, No. 221 / Friday, November 15, 2019 / Rules and Regulations (pages 62678-62681)

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Restraint & Seclusion

Prior to December 2019
Medicare Conditions of Participation stated:

§ 482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

Licensed Independent Practitioner
An individual authorized to provide care and services without direction or supervision

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Restraint & Seclusion

- CMS changed term "Licensed Independent Practitioner" to "Licensed Practitioner
- Effective November 29, 2019
- Resulted from ongoing AAPA advocacy

482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

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NEW Joint Commission Elements of Performance Effective 3/15/20

PC.03.05.05
The hospital initiates restraint or seclusion based on an individual order.

Elements of Performance for PC.03.05.05

1. A physician~~, clinical psychologist,~~ or other authorized licensed ~~independent~~ practitioner ~~primarily~~ responsible for the patient's ~~ongoing~~ care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.

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Restraint & Seclusion

For PAs to order restraint and the following criteria must be met:

- Consistent with hospital bylaws and policies
- Included as part of a PA's scope of practice, practice agreement, and granted privileges
- Not prohibited by State laws or regulations

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Hospice – PAs as "Attending Physician"

Before Jan 1, 2019	After Jan 1, 2019
▪ PAs not permitted to provide care directly related to a hospice patient's terminal illness ▪ Physicians and NPs able to provide and be reimbursed for these services	▪ Medicare definition of hospice "attending physician" broadened to include PAs ▪ PAs permitted to provide, manage, be reimbursed by Medicare for hospice services

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PAs and Hospice

Physicians

- Certify Terminal Illness
- Serve as Hospice Attending
- Conduct Face-to-Face Visit for Recertification (if needed)
- Order Medications for Hospice Beneficiaries (no restrictions)

Physicians & NPs

- Serve as Hospice Attending
- Conduct Face-to-Face Visit for Recertification (if needed)
- Order Medications for Hospice Beneficiaries (no restrictions)

PAs

- Serve as Hospice Attending
- Order Medications for Hospice Beneficiaries with Restrictions

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PAs and Hospice

To order medications for a Medicare hospice beneficiary, a PA must:

- Be serving as a patient's "attending physician"
- Not an employee of, or under arrangement with, the hospice

https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf?utm_source=federalregister.gov&utm_medium=email&utm_campaign=pi+subscription+mailing+list

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Durable Medical Equipment

- PAs authorized to order and certify necessity for DME
- Certain DME require face-to-face encounter within 6 months of order
  - PAs authorized to perform face-to-face encounter

Medicaid was unclear

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Durable Medical Equipment

- No stand-alone category for DME in Medicaid statute
  - Only mention of DME is under Home Health section
  - Since Home Health could only be ordered by a physician, an increasing number of state Medicaid programs interpreted DME to require a physician order
- Statutory and Regulatory Fix
  - CARES Act & COVID-19 Public Health Emergency Interim Rules
  - Authorized PAs (and NPs) to order/certify Home Health & DME for Medicaid beneficiaries

https://www.cms.gov/files/document/covid-final-ifc.pdf

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Home Health Services

- Refers to services delivered through a home health agency to homebound patients
- Only a physician could
  - Certify/recertify need for home health
  - Establish plan of care
- PAs (and NPs) could perform
  - Face-to-Face Visit
  - Provide care plan oversight

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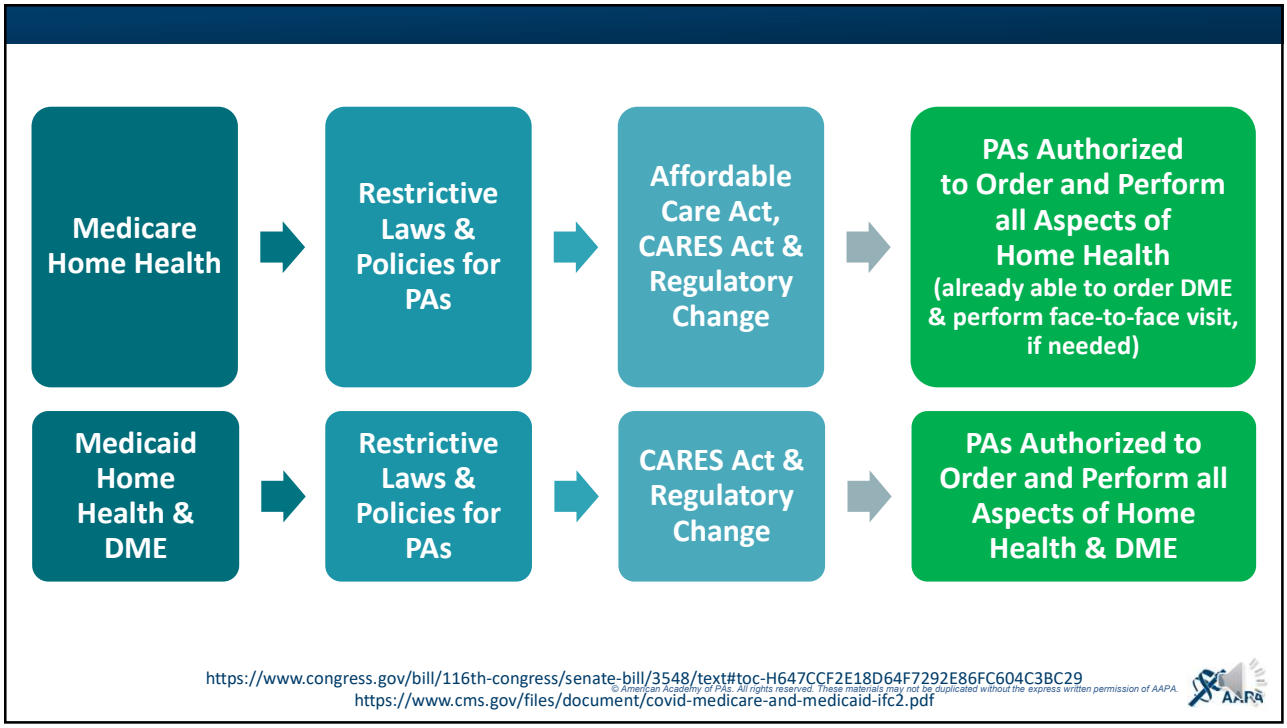
Home Health Services & CARES Act

- Amended Social Security Act to permanently allow PAs (and NPs) to order/certify Home Health & establish 'plan of care' for Medicare beneficiaries
- Allowed up to 6 months for HHS to revise existing regulations related to home health
- Mandated that changes to Medicaid be made in the same manner as Medicare

CARES Act of 2020

https://www.congress.gov/bill/116th-congress/senate-bill/3548/text#toc-H647CCF2E18D64F7292E86FC604C3BC29



https://www.congress.gov/bill/116th-congress/senate-bill/3548/text#toc-H647CCF2E18D64F7292E86FC604C3BC29
https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

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Student Documentation

Former CMS Policy

Only teaching physicians could use documentation in the medical record made by medical students

New CMS Policy (January 1, 2020)

Physicians, PA and APRNs may review & verify, rather than redocument, information recorded by:

- Medical students, residents, and physicians
- PA and APRN students
- Other members of the medical team

https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar

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Student Documentation

Caveats & Best Practices

- Must be allowed by hospital/facility policy
- Provider submitting claim for service should:
  - Personally examine & evaluate patient
  - Review & verify accuracy of student documentation
  - Sign & date note
    (with necessary, if any, updates to documentation)

May require changes to existing EHR software & programming

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EMTALA

- Ensures access to emergency services regardless of ability to pay
- Requires medical screening examination (MSE) of emergency medical condition (EMC)
- Must provide stabilizing treatment of EMCs
- Must arrange appropriate transfer if not capable of providing stabilizing treatment or if patient requests

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EMTALA

If consistent with scope of practice and hospital policy, PAs (& NPs) may perform the following in compliance with EMTALA:

- Medical screening exam
- Certifying false labor
- Transferring patients (if physician not present in ED)

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf

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EMTALA

- Hospitals must maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an EMC after initial examination
- If a physician on the list is called to provide emergency screening or treatment and fails or refuses to appear within a reasonable period of time, the hospital and physician may be in violation of EMTALA

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter08-15.pdf

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Do I need to be concerned about healthcare compliance?

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MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

"I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization."

"I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

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False Claims Act

Imposes civil liability on "any person who **knowingly** presents, or **causes** to be presented a false or fraudulent claim for payment."

Knowingly means a person has "actual knowledge of the information", acts in "**deliberate ignorance**", or **reckless disregard**" of the truth or falsity.

"**No proof of specific intent** to defraud is required to violate the civil FCA."

https://www.govinfo.gov/content/pkg/USCODE-2010-title31/pdf/USCODE-2010-title31-subtitleIII-chap37-subchapIII-sec3729.pdf

False Claims Act

In addition to refunding payments and costs to the Federal government for civil action:

- Treble damages (up to 3X amount violator received)
- Civil monetary penalties (up to $22,363 per false claim)
- Additional fines and/or imprisonment
- Exclusion from Medicare, Medicaid, and all other Federal healthcare programs

https://www.govinfo.gov/content/pkg/FR-2018-01-08/pdf/2017-28230.pdf

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Anti-Kickback Statute

- Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals that generate Federal health care program business
- False Claims Act liability, criminal fines, civil monetary penalties, prison term (up to 5 years per violation), exclusion from Federal programs

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

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Stark Law

- AKA 'Physician Self-Referral Statute'
- Prohibits a physician from referring Medicare patients for health services to an entity with which the physician (or immediate family member) has a financial relationship
- Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
- False Claims Act liability, civil monetary penalties, exclusion from Federal programs

Law specifically applies to physicians; implications for PAs, who are advised to follow law as if it directly applies to them

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

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Federal Health Care Fraud Statute 18 USC 1347

- "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program. . ."
  - "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual"
- Under the *federal constructive knowledge standard*, if a person should have knowledge had he or she made "usual and proper inquiries", this can be enough to establish knowledge in some cases.

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Federal Health Care Fraud Statute 18 USC 1347

- Fines
  - $250,000 (for individuals)
  - $500,000 (for organizations)
- Imprisonment
  - 10 years (general offenses)
  - 20 years (fraud results in serious bodily injury)
  - Life sentence (fraud results in death)

https://www.law.cornell.edu/uscode/text/18/1347
https://www.law.cornell.edu/uscode/text/18/3571
https://federal-lawyer.com/federal-health-care-fraud-statute/

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DOJ "Yates Memo"

- **Subject: Individual Accountability for Corporate Wrongdoing**
- **From: Deputy Attorney General, Sally Quillian Yates**
- **Date: September 9, 2015**

"Fighting corporate fraud and other misconduct is a top priority of the Department of Justice."

"One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing."

"The Department will not release culpable individuals from civil or criminal liability when resolving a matter with a corporation."

https://www.justice.gov/archives/dag/file/769036/download

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Since Yates Memo

- Sentences for healthcare fraud offenders with a **leadership or supervisory role** in the offense:
  - ↑ 22.0% in FY 2015
  - ↑ 19.9% in FY 2016
  - ↑ 26.8% in FY 2017
- Punishment (in FY 2017)
  - 80.3% of offenders sentenced to imprisonment
  - Average sentence was 37 months

https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Health_Care_Fraud_FY15.pdf
https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Health_Care_Fraud_FY16.pdf
https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Health_Care_Fraud_FY17.pdf

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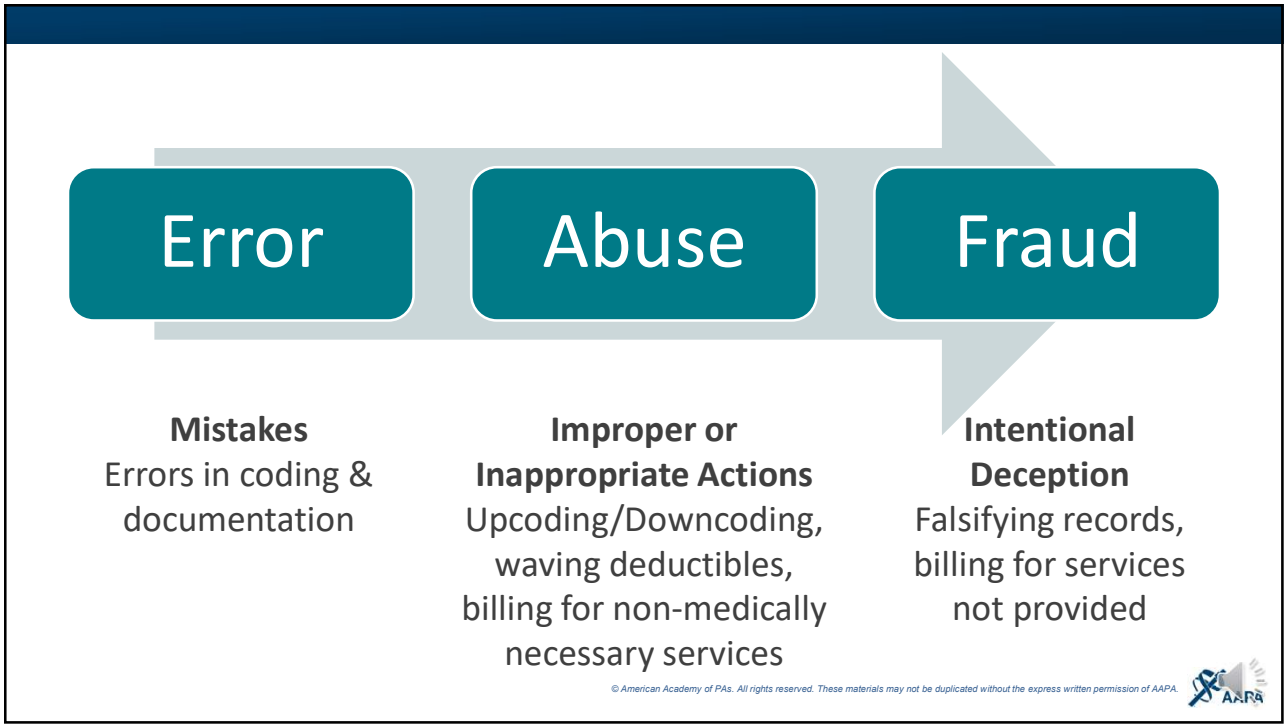

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Fraud & Abuse: By the Numbers

5 billion recovered in FY 2019	**809** criminal actions	**695** civil actions	**2,640** excluded from participation

https://oig.hhs.gov/reports-and-publications/archives/semiannual/2019/2019-fall-sar.pdf

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Whistleblowers: By the Numbers

600+
whistleblower cases each year

$2.1 of $3
billion in FCA settlements from whistleblowers in 2019

30%
of recovered funds eligible to whistleblowers

https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019

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"Repeat whistleblowers reap millions of dollars in false-claims suits"
Roving whistleblower gets latest win in $18 million deal
(Law360, April 12, 2018)
A doctor, a "so-called serial whistleblower", earned $38 million from whistleblower suits
(ABA Journal, July, 24, 2014)
BREAKING NEWS
LIVE

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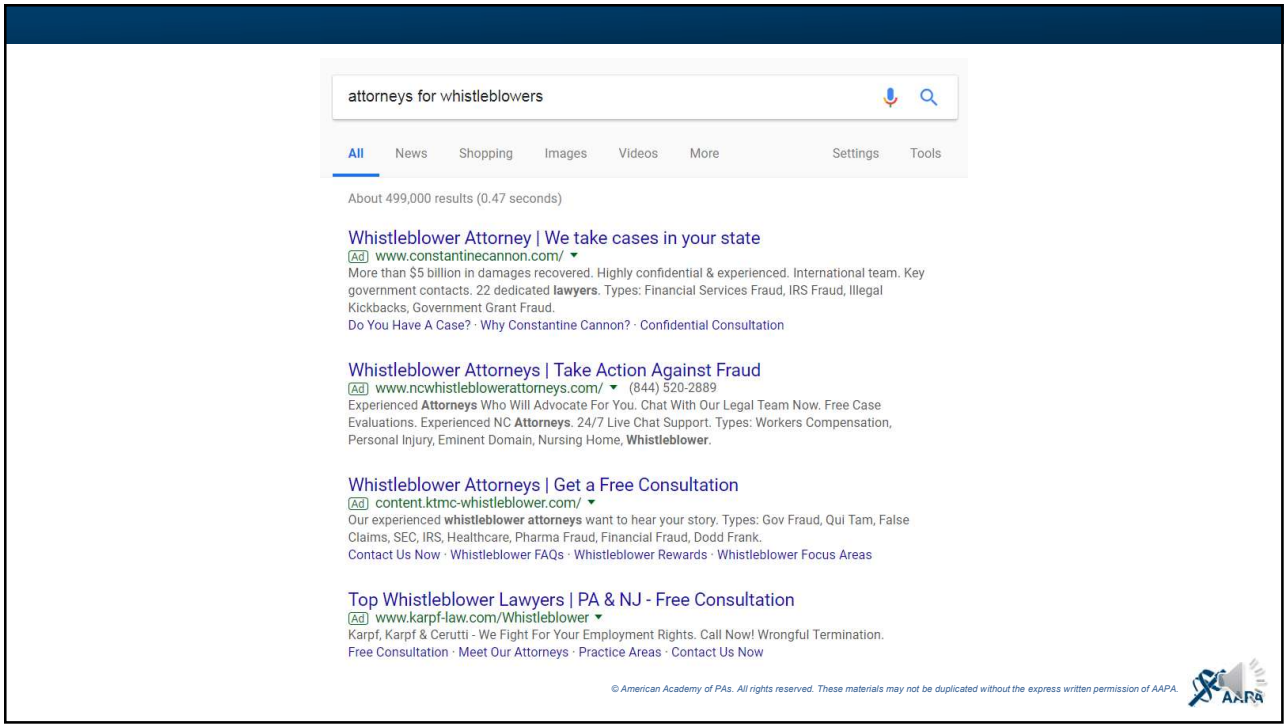
attorneys for whistleblowers
All
News
Shopping
Images
Videos
More
Settings
Tools
About 499,000 results (0.47 seconds)
Whistleblower Attorney | We take cases in your state
Ad www.constantinecannon.com/
More than $5 billion in damages recovered. Highly confidential & experienced. International team. Key government contacts. 22 dedicated lawyers. Types: Financial Services Fraud, IRS Fraud, Illegal Kickbacks, Government Grant Fraud.
Do You Have A Case? · Why Constantine Cannon? · Confidential Consultation
Whistleblower Attorneys | Take Action Against Fraud
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Ad content.ktmc-whistleblower.com/
Our experienced whistleblower attorneys want to hear your story. Types: Gov Fraud, Qui Tam, False Claims, SEC, IRS, Healthcare, Pharma Fraud, Financial Fraud, Dodd Frank.
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Department of Justice

U.S. Attorney's Office

District of Massachusetts

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FOR IMMEDIATE RELEASE

Friday, March 29, 2019

CareWell Urgent Care Center Agrees to Pay $2 Million to Resolve Allegations of False Billing of Government Health Care Programs

BOSTON – The United States Attorney's Office announced today that CareWell Urgent Care Centers of MA, P.C., CareWell Urgent Care of Rhode Island, P.C., and Urgent Care Centers of New England Inc. (CareWell), the owners and operators of urgent care centers located throughout Massachusetts and Rhode Island, have agreed to pay $2 million to resolve allegations that they violated the False Claims Act by submitting inflated and upcoded claims to Medicare, Massachusetts Medicaid (MassHealth), the Massachusetts Group Insurance Commission (GIC), and Rhode Island Medicaid.

https://www.justice.gov/usao-ma/pr/carewell-urgent-care-center-agrees-pay-2-million-resolve-allegations-false-billing

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EHR Fraud Vulnerabilities

Allegations against CareWell

- Used EHR templates and other methods to document more than medically necessary and cause submission of "inflated and upcoded claims to Medicare"
- "engaged in a calculated scheme to reap unjustified economic benefit for their own gain"

https://www.justice.gov/usao-ma/pr/carewell-urgent-care-center-agrees-pay-2-million-resolve-allegations-false-billing

EHR Fraud Vulnerabilities

- Safeguarding against use of EHR in fraud and abuse – top priority of CMS & OIG
- Cloning, copy & paste, auto-fill, macros, pre-populated templates
  - Subject of targeted probes
  - May be considered failure to meet documentation of medical necessity, lead to recoupment of payments for services, and be considered fraud

https://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf
https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2018.pdf
https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Part%20B~EM%20Help%20Center~General%20Articles~Medical%20Record%20Cloning?open&Expand=1

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Upcoding

- Billing a higher level of service than was
  - Performed
  - Documented
  - Medically Necessary

Downcoding

- Billing a lower level of service than was
  - Performed
  - Documented

Both are considered inappropriate billing and examples of healthcare abuse

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JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Tuesday, October 21, 2014

Miami-Area Physician Assistant Sentenced to 15 Years in Prison for $200 Million Medicare Fraud Scheme

A Miami licensed physician assistant was sentenced today to serve 15 years in prison for participating in a Medicare fraud scheme involving approximately $200 million in fraudulent billings by American Therapeutic Corporation (ATC), a mental health company that was headquartered in Miami.

Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, U.S. Attorney Wifredo A. Ferrer of the Southern District of Florida, Special Agent in Charge George L. Piro of the FBI's Miami Field Office and Special Agent in Charge Derrick Jackson of the Health and Human Services Office of Inspector General's (HHS-OIG) Florida region made the announcement.

https://www.justice.gov/opa/pr/miami-area-physician-assistant-sentenced-15-years-prison-200-million-medicare-fraud-scheme

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JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Wednesday, September 18, 2019

Charges Brought Against 34 Individuals for Alleged West Coast Medicare and Medicaid Fraud Schemes Totaling $258 Million

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division announced today a health care fraud enforcement action in the state of California, involving charges brought against a total of 26 individuals in the Central District of California for their alleged involvement in Medicare and Medicaid fraud schemes resulting in $257

Hilda Haroutunian, 59, of Sun Valley, California, Keyvan Amirikhorheh, M.D., 60, of Seal Beach, California, Lorraine Watson, 56, a physician's assistant, of Valley Village, California, Noem Sarkisyan, 63, of North Hollywood, California, and Edmond Sarkisyan, 40, a medical assistant, of North Hollywood, California, were charged for their alleged participation in

https://www.justice.gov/opa/pr/charges-brought-against-34-individuals-alleged-west-coast-medicare-and-medicaid-fraud-schemes

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Department of Justice

U.S. Attorney's Office

Eastern District of Pennsylvania

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FOR IMMEDIATE RELEASE

Wednesday, February 6, 2019

Fourteen Individuals Charged for Operating "Pill Mills" and Illegally Prescribing Drugs to Hundreds of Patients in Multiple Locations in the Philadelphia Area

70, of Elkins Park, PA; Dr. Frederick Reichle, 83, of Warrington, PA; Dr. Marcus Rey Williams, 70, of Coatesville, PA; Dr. William Demedio, 58, of Springfield, PA; Dr. Neil Cutler, 77, of Warminster, PA; Physician's Assistant Mitchell White, 33, of Philadelphia, PA; Physician's Assistant Jason Dillinger, 40, of West Chester, PA; Physician's Assistant Debra Cortez, 56, of Bristol, PA; Physician's Assistant Samantha Hollis, 42, of Wilmington, DE, and Office Manager Joanne Rivera, 35, of Pennsauken, NJ. Each defendant

wo indictments charging
ute controlled
edical purpose;
emises. These charges
and local agencies. U.S.
Attorney McSwain announced these charges as part of a press conference held today to highlight the
Eastern District

"Healthcare providers who ignore their Hippocratic oaths and put illegal prescription drugs on our streets are nothing more than drug dealers in white lab coats," said Maureen R. Dixon, Special Agent in Charge of the Philadelphia Regional Office of the Inspector General for the Department of Health and Human Services (HHS-OIG). "Medical providers who disregard the law and put greed in front of helping patients can expect criminal repercussions."

https://www.justice.gov/usao-edpa/pr/fourteen-individuals-charged-operating-pill-mills-and-illegally-prescribing-drugs

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Department of Justice

U.S. Attorney's Office

District of Maryland

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FOR IMMEDIATE RELEASE

Friday, July 12, 2019

Physician Assistant Pleads Guilty To Federal Drug Charge For Conspiring To Distribute And Dispense Oxycodone, Fentanyl, Methadone, And Alprazaolam At A Pain Management Practice With Offices In Towson And Owings Mills

Defendant Knew Many Patients Lacked Legitimate Medical Need for Prescriptions, and Engaged in Sexual Contact with Patients Attempting to Get Prescriptions

Baltimore, Maryland – William Soyke, age 66, of Hanover, Pennsylvania, pleaded guilty today to conspiracy to distribute and dispense oxycodone, fentanyl, methadone, and alprazolam outside the scope of professional practice and not for a legitimate medical purpose.

https://www.justice.gov/usao-md/pr/physician-assistant-pleads-guilty-federal-drug-charge-conspiring-distribute-and-dispense

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Department of Justice

U.S. Attorney's Office

Southern District of New York

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FOR IMMEDIATE RELEASE

Tuesday, December 15, 2015

Staten Island Physician's Assistant Sentenced In Manhattan Federal Court To 11 Years In Prison For Massive Oxycodone Distribution Conspiracy

Preet Bharara, the United States Attorney for the Southern District of New York, announced today that LEONARD MARCHETTA, a physician's assistant, was sentenced in Manhattan federal court to 11 years in prison for cons for large doses of oxycodone, typically 150 30-milligram tablets. MARCHETTA also received a separate clinic. MARCI fee of approximately $500 in cash for each medically unnecessary oxycodone prescription he issued. On a Judge P. Kevin number of occasions, MARCHETTA issued prescriptions in the names of fictitious individuals or individuals whom MARCHETTA never saw in exchange for cash. In total, MARCHETTA wrote medically unnecessary prescriptions for more than 125,000 30-milligram oxycodone pills during a period of approximately three years.

https://www.justice.gov/usao-sdny/pr/staten-island-physician-s-assistant-sentenced-manhattan-federal-court-11-years-prison

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Ryan Haight Online Pharmacy Consumer Protection Act

- Federal law enacted in 2008
- Created to regulate internet prescriptions
- Prohibits providers from prescribing controlled substances to patients they have not examined in person

https://www.govtrack.us/congress/bills/110/hr6353/text

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Overlapping Surgery

- Physician must be physically present during all **critical or key portions** of the procedure and be immediately available during the entire procedure
  - Those in which the essential technical expertise and surgical judgment of the surgeon is required to achieve an optimal patient outcome (ACS)
  - Opening and closing of surgical site is generally not critical (CMS & ACS)

Hospitals should have policies regarding overlapping surgeries and safeguards to prevent concurrent surgeries.

https://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf

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Whistle-blower files suit over alleged double-booked surgeries

by Jonathan Saltzman and Todd Wallack Boston Globe

Orthopedic surgeons at Massachusetts General Hospital repeatedly kept patients waiting under anesthesia longer — sometimes more than an hour longer — than was medically necessary or safe, as they **juggled two or even three simultaneous operations**, according to a federal lawsuit that alleges frequent billing fraud at the prestigious hospital.

Dr. Lisa Wollman, a former anesthesiologist at Mass. General, alleges in the lawsuit that at least five surgeons endangered patients by regularly performing simultaneous surgeries. Wollman charges that the doctors also **defrauded the government by submitting bills for surgeries in which they were not in the operating room for critical portions of procedures**, leaving the work to unsupervised trainees.

https://www.bostonglobe.com/metro/2017/06/07/mgh-surgeons-left-patients-waiting-under-anesthesia-while-they-did-second-surgeries-whistle-blower-charges/QshFeHhRn92WOSwDEIi1LO/story.html

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Surgical Assisting at Teaching Hospitals

- Based on the Social Security Act, Medicare does not generally reimburse for first assistant fees if there is a qualified resident available
- Teaching Hospital Exception allowed:
  - No qualified resident available (in required training/clinic-hours or resident-hour restrictions)
  - Physician NEVER uses a resident in pre-, intra-, and post-op care
  - Exceptional medical circumstances (e.g. multiple traumatic injuries)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Surgical Assisting at Teaching Hospitals

When no qualified resident available:

- Physician must certify

  I understand that § 1842(b)(7)(D) of the Act (follow the link and select the applicable title) generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).

- Must use modifier -82

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Duke University Health System, Inc. Agrees To Pay $1 Million For Alleged False Claims Submitted To Federal Health Care Programs

Department of Justice March 21, 2014

Duke University Health System allegedly made false claims to Medicare, Medicaid, and TRICARE by (1) **billing the government for services provided by physician assistants (PA's) during coronary artery bypass surgeries when the PA's were acting as surgical assistants (along with graduate medical trainees), which is not allowed under government regulations** and (2) increasing billing by unbundling claims when the unbundling was not appropriate, specifically in connection with cardiac and anesthesia services.

https://www.bostonglobe.com/metro/2017/06/07/mgh-surgeons-left-patients-waiting-under-anesthesia-while-they-did-second-surgeries-whistle-blower-charges/QshFeHhRn92WOSwDEIi1LO/story.html

Medicare Payment & Employment Arrangements

- Physicians who are not employed by the same entity as the PA have no ability to bill for work provided by PAs
- OIG determined that it is improper for physicians to enter into arrangements that relieve them of a financial burden that they would otherwise have to incur

Particularly problematic with a hospital-employed PA and non-hospital employed physician

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Work being performed by a hospital-employed PA for a physician not employed by the same entity is subject to:

Anti-Kickback

Inurement for referrals to hospital

Stark Law

Remuneration (indirect compensation) by the hospital

False Claims Act Liability

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U.S. attorney investigating DMC over possible federal anti-kickback violations

by Jay Greene **Crain's Detroit Business**

. . . **termination of the employment of 14 nurse practitioners and physician assistants was due, in part,** to the company's concerns that their prior employment did not comply with the **Anti-kickback Statute, the Stark law and False Claims Act**.

. . . **services the NPs and PAs were delivering to private doctors** might run afoul of federal laws designed to prevent improper patient referrals to the hospital.

. . . **blatant violations** would be a hospital paying fees for admissions or services, but **could** also **include** offering doctors office leases at below market value, or free or discounted services like **advanced-practice providers' coverage of private doctors' patients.**

https://www.crainsdetroit.com/article/20180228/news/654046/us-attorney-investigating-dmc-over-possible-federal-anti-kickback

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After it Self-Disclosed Conduct to the OIG, Inova Health Care Services Agreed to Pay $528, 158

Healthcare FMV Advisors

. . . agreed to pay $528,158 for allegedly **violating** the Civil Monetary Penalties Law **provisions applicable to kickbacks and physician self-referrals**.

The OIG alleged that Inova **paid remuneration** to Arrhythmia Associates (AA) **in the form of services provided by certain PAs within the office of AA**. Specifically, Inova provided PA service to AA without written contract in place and failed to bill and collect for those PA services.

http://www.healthcarefmvadvisors.com/NewsUpdates/tabid/63/Entryid/13/After-it-self-disclosed-conduct-to-the-OIG-Inova-Health-Care-Services-d-b-a-Inova-Fairfax-Hospital-Inova-Virginia-agreed-to-pay-528-158.aspx

Chicago Hospital Scam Had "Kickback on Steroids", Jury Told

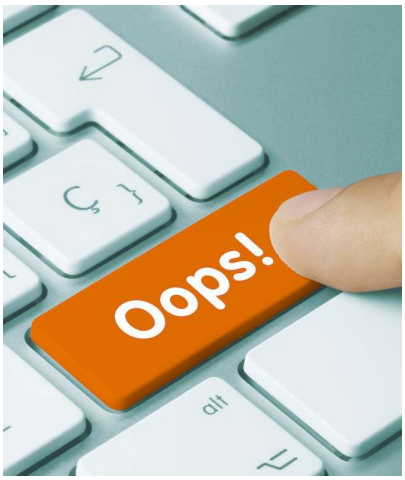
by Lance Duroni
Law 360

. . . Assistant U.S. Attorney Ryan Hedges walked the jury through . . . how the **hospital cloaked illegal payments** to doctors.

. . . the defendants took the conspiracy to a "whole new level" when they began loaning out mid-level medical professionals, including physician assistants and nurse practitioners, to doctors free-of-charge in return for patients, Hedges said, calling the maneuver **"kickbacks on steroids"**.

https://www.law360.com/articles/630708/chicago-hospital-scam-had-kickbacks-on-steroids-jury-told

77



- Consult with compliance and in-house counsel
- Follow Provider Self-Disclosure protocol
  - Opportunity to minimize penalties and fines
- Report and return "overpayments"
  - Obligation to:
    - report and return funds from the past 6 years
    - that a person or organization is not entitled
    - within 60 days of identifying the overpayment
  - Failure to do so is liable to False Claims Act penalties

https://www.cms.gov/newsroom/fact-sheets/medicare-reporting-and-returning-self-identified-overpayments

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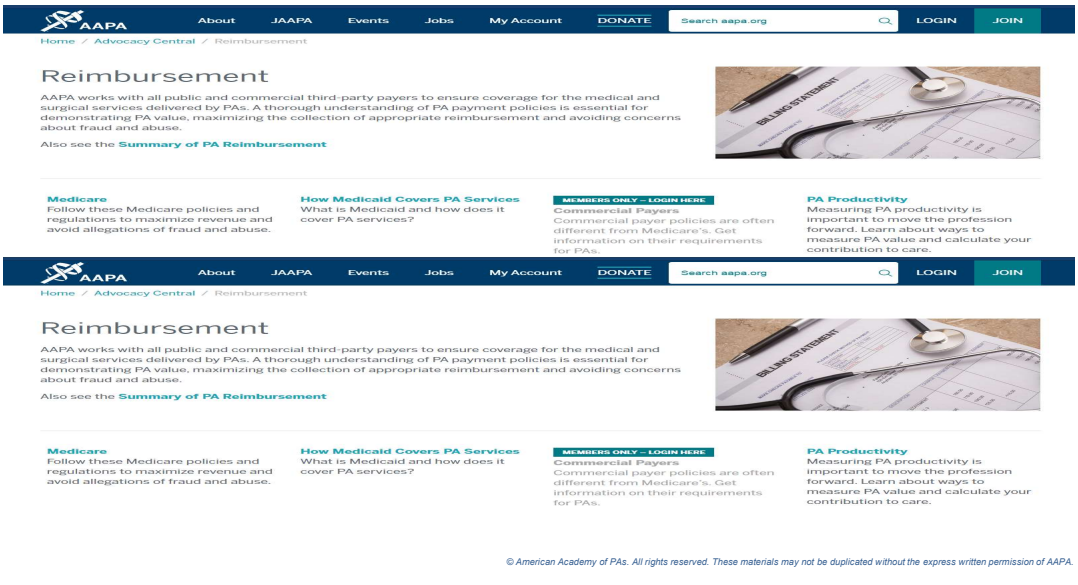
https://www.aapa.org/advocacy-central/reimbursement



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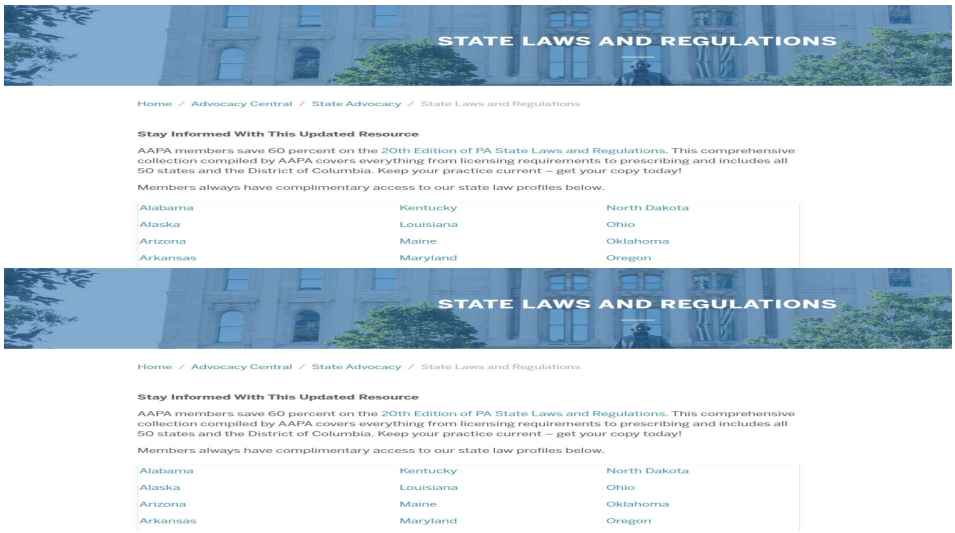
https://www.aapa.org/advocacy-central/state-advocacy/state-laws-and-regulations/



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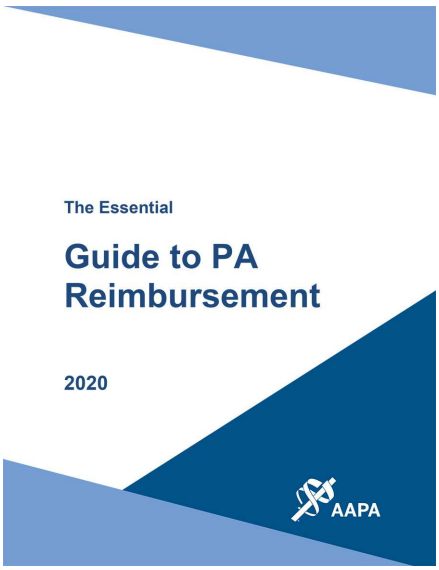

$25 for members

https://www.aapa.org/shop/essential-guide-pa-reimbursement-2020/

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Additional References & Resources

- Medicare Claims Processing Manual
  - Chapter 12 – Physicians/Nonphysician Practitioners

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
  - Chapter 15 – Covered Medical and Other Health Services

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Code of Federal Regulations
  - Title 42 – Public Health

    https://www.ecfr.gov/cgi-bin/text-idx?SID=28cbafbbd980d94723375b715d900a73&mc=true&tpl=/ecfrbrowse/Title42/42tab_02.tpl

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thank you!

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