CORPORATE COMPLIANCE

MARYLAND DEPARTMENT OF HEALTH

OFFICE OF THE INSPECTOR GENERAL

DIVISION OF CORPORATE COMPLIANCE

The Office of the Inspector General

The mission of the Office of the Inspector General is to promote integrity and accountability within the Maryland Department of Health; to deter, detect and investigate fraud, waste, abuse and employee misconduct; and to disseminate actionable and meaningful recommendations with the goal of protecting the interests of the State and its resources.

The Office of the Inspector General (OIG) is an independent unit within the Maryland Department of Health made up of auditors, investigators, compliance officers, data analysts and career professionals dedicated to its mission and serving all Marylanders.

Corporate Compliance Program

The Maryland Department of Health (MDH, the Department) is committed to maintaining an effective compliance program in accordance with the Compliance Program Guidance published by the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG). The MDH Corporate Compliance Program (CCP) has been designed to help prevent and detect violations of and compliance with applicable federal and state laws.

The CCP was established to create a culture that emphasizes honest and ethical behavior by every employee in the organization; Maintain compliance with applicable federal and state laws, regulations and legislation; Effectively manage the department's resources and risk; and insure accountability of all persons within the organization.

The Division of Corporate Compliance

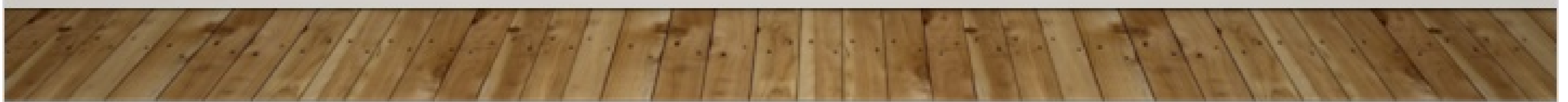
The MDH Corporate Compliance Program consists of: 1) the Inspector General of the MDH who reports to the Secretary of MDH; 2) the Chief Compliance Officer, who reports to the MDH Inspector General on the progress of the program and its efforts; and 3) the MDH Corporate Compliance Committee, which assists and advises the Chief Compliance Officer on healthcare compliance standards and the MDH Code of Conduct.

The Division of Corporate Compliance within the Office of the Inspector General is responsible for administering this program.

The Division of Corporate Compliance is here to help with …..

- Educating and training personnel on their legal and ethical obligations under Federal and State laws.
- Investigating allegations concerning suspected unethical or improper activities by members of the MDH workforce or its contractors.
- Providing guidance for program and institution directors and local health officers on issues relating to compliance.
- Establishing resources for reporting fraud, waste, or abuse in the Department, which encourages employees to file complaints without fear of retaliation.

HEALTH CARE LAW

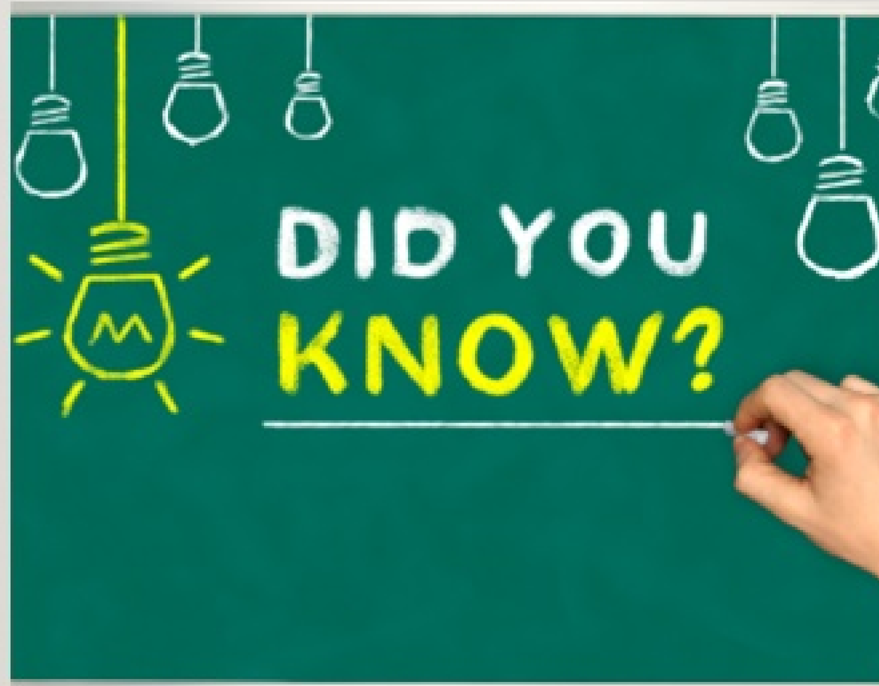


Medicaid

- Originated as a means of ensuring healthcare coverage and services for low income and financially needy people.
- Administered by the states; jointly funded by both federal and state governments.
- Each state's Medicaid program reimburses providers directly for services provided to Medicaid beneficiaries from funds received from the federal government.
- The Maryland Department of Health investigates Medicaid provider and recipient fraud, while the Maryland Office of the Attorney General Medicaid Fraud Control Unit prosecutes Medicaid fraud and abuse cases.

Medicare

- Established in 1965, (Title XVII of the Social Security Act)
- Medicare is a federally funded health insurance program for citizens 65 years or older; persons who have a long term disability; as well as persons who have end stage renal disease as defined by the Social Security Act.
- The Office of Investigations for the United States Department of Health and Human Services Office of Inspector General (HHS/OIG) collaboratively works with the Federal Bureau of Investigation (FBI) in order to combat Medicare Fraud. Defendants convicted of Medicare fraud face stiff penalties according to the Federal Sentencing Guidelines and disbarment from HHS programs.


DID YOU
KNOW?

These Federal and State agencies are involved in combating healthcare fraud

United States Department of Health and Human Services Office of the Inspector General

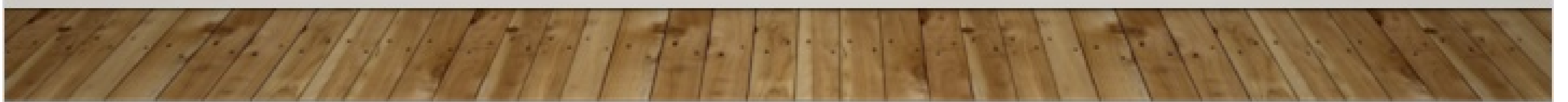
United States Department of Health and Human Services Office of Civil Rights

United States Department of Justice

Maryland Office of the Attorney General Medicaid Fraud Control Unit

Maryland Department of Health Office of the Inspector General

Code of Conduct



EMPLOYEE RESPONSIBILITIES

While carrying out the Department's mission, all employees are expected to conduct the Department's business in a consistent and professional manner, adhering to the following principles:

EMPLOYEE RESPONSIBILITIES

Perform all activities in compliance with pertinent laws and regulations, including those applying to fraud and abuse, false claims, self-referral prohibitions, anti-trust, employment discrimination, environmental protection, lobbying and political activity, and the Maryland Public Ethics Law

EMPLOYEE RESPONSIBILITIES

Participate in and promote high standards of business ethics and integrity. Maryland Department of Health employees must not engage in any activity intended to defraud anyone of money, property or services

EMPLOYEE RESPONSIBILITIES

Perform all duties accurately and honestly

EMPLOYEE RESPONSIBILITIES

Maintain appropriate levels of confidentiality as it relates to the public and other Maryland Department of Health employees by protecting personal information and referring inquiries to designated officials

EMPLOYEE RESPONSIBILITIES

Conduct business transactions with suppliers, vendors, contractors and other third parties free from offers or solicitations of gifts and favors, or other improper inducements

EMPLOYEE RESPONSIBILITIES

Avoid conflicts of interest, in appearance or fact, in the conduct of all activities. In the event that there are conflicts, Maryland Department of Health employees must take prompt, appropriate action to make full disclosure to the appropriate authorities

EMPLOYEE RESPONSIBILITIES

Preserve and protect the Department's assets by making prudent and effective use of resources, property, and accurate financial reporting

EMPLOYEE RESPONSIBILITIES

Refrain from presenting or causing to be presented, any claim or billing for services not provided, or that the individual knows to be false or fraudulent

EMPLOYEE RESPONSIBILITIES

All Maryland Department of Health (MDH) employees have an obligation to report to the Office of the Inspector General any incidents of suspected fraud, waste, abuse, or misconduct occurring within MDH that violate any laws, MDH policies, or the Code of Conduct

To report fraud, waste, and abuse call….

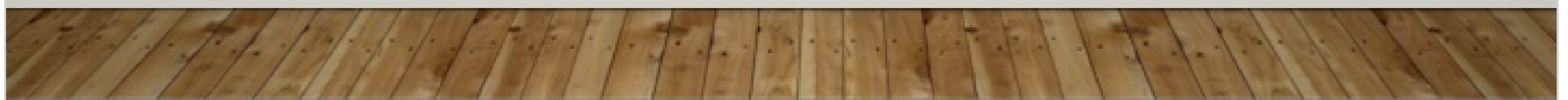
1-866-770-7175

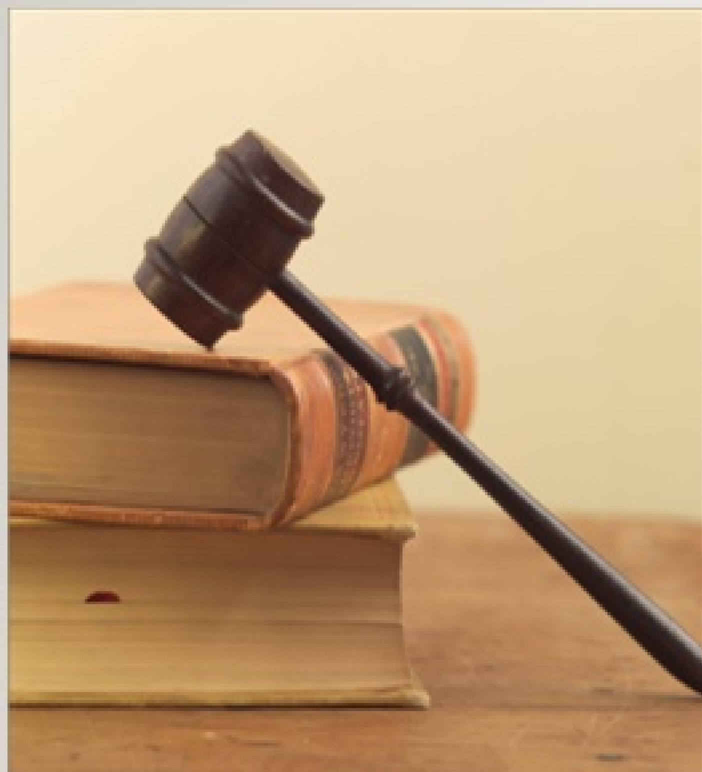
Reporting Fraud, Waste, and Abuse
Reports to the OIG may be made:

Anonymously

Orally or in writing

Using the OIG Hotline: **1-866-770-7175**
or
Using the OIG website: http://health.maryland.gov/oig





Frequently Used Health Care Laws

In the following section, a select few of the frequently used health care laws will be briefly defined.

Of the frequently used health care laws, there are some laws that every compliance professional should be familiar with.

Click on the boxes below to view the information.

Anti-Kickback Statute	Civil Monetary Penalty Law	Civil False Claims Act	HIPAA	Physician Self Referral Act	Deficit Reduction Act

Continue

HIPAA

The Law Defined

HIPAA's intent is to reform the health care industry by:

1. Reducing costs;
2. Simplifying administrative and burdens; and
3. Improving the privacy and security of patients' information.

The Purpose of HIPAA

1. To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets
2. Combat waste, fraud, and abuse in health insurance and health care delivery
3. Promote the use of medical savings accounts,
4. Improve access to long-term care services and coverage,
5. Simplify the administration of health insurance, and for other purposes.

Civil False Claims Act

The Law Defined

Civil False Claims Act (FCA) - Title 31 of the United States Code (USC) Sections 3729 - 3733. The civil FCA makes it illegal to present (or cause to be presented) a claim to the federal government for payment or for approval when the person or entity submitting the claim "knows" that the claim is either:

a. False

b. Fraudulent; or

c. Acts in reckless disregard as to the truth or falsity of the claim, record or statement.

Key Elements

1. Provides sanctions for anyone submitting a false; or fraudulent claim to the federal government; or
2. Uses false records or statements to obtain payment from the federal government for a false or fraudulent claim
3. Violators are liable to the federal government and subject to a "civil" penalty of $5,500 - $11,000 per claim, plus three time the amount of damages that the federal government sustains because of the act of that person.
4. In addition to civil penalties provided for in the FCA, violators are subject to additional penalties imposed by the OIG of DHHS to include:

a. Civil monetary penalties

b. Prospective exclusion from participation in all federal and state health care programs

(See USC Title 31 §§ 3801 - 3812, Title 42, § 1320a - 7a and related regulations).

Continue

Civil False Claims Act - continued

Whistleblower (Qui Tam) Provisions

Under the FCA, a private person known as a "Qui Tam Relator" or Whistleblower may bring a suit on behalf of the Federal Government to recover federal funds used to pay false or fraudulent claims:

A. If the government proceeds with a case initiated by a Qui Tam Relator and is successful in winning, the Relator gets 15% - 25% of the proceeds.

B. If the government declines the case and the Relator wins or settles on his her own, he/she is entitled to 25% - 30% of the proceeds plus reasonable costs and attorney fees.

C. Protections for the Whistleblower-

1. Protected from being discharged from their place of employment;
2. Demoted;
3. Suspended;
4. Threatened;
5. Harassed; or
6. Discriminated against in terms of conditions of employment by their employer for being a Whistle Blower

Return to the Health Care Laws Menu

Deficit Reduction Act

The Law Defined

Under the Deficit Reduction Act of 2005 *any employer who receives more than $5 million in Medicaid payments per year is required to provide information to its employees regarding the following*:

1. The Federal FCA and any applicable state FCAs;
2. Rights of employees to be protected as whistleblowers; and
3. The Employer's policies for detecting and preventing fraud waste and abuse

Continue

Deficit Reduction Act - Key Elements

A. On February 8, 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005 (DRA)

B. The (DRA), Section 6032 mandates that certain entities (e.g., States) participating in Medicaid programs inform their employees, contractors and agents about the details of state and federal false claim statutes and whistle blower protections.

C. Jan. 1, 2007 was the deadline for states' compliance with section 6032 or the DRA

D. Section 6032 entitled "Employee Education About False Claims Recovery" requires entities (e.g., MDH), who wither receive or make $5 million in annual Medicaid payments, to establish specific written policies for all of their employees, and any contractors and agents.

E. Entities (e.g., MDH) written policies must include information about:

1. The federal FCA
2. Remedies for false claims and statements
3. Any state laws pertaining to civil or criminal penalties for false claims and statements
4. The Whistle Blower protections under the federal FCA and state laws
5. The role of such laws in preventing and detecting fraud, waste and abuse in federal healthcare programs

Continue

Deficit Reduction Act - Key Elements

6. The entity's (MDH) policies and procedures for detecting and preventing fraud, waste and abuse (i.e., the MDH Corporate Compliance Program
7. Wherein any Employee Handbook of the entity (MDH), a specific discussion of:
   a. State and federal laws;
   b. The rights of employees to be protected as "Whistle Blowers";
   c. The entity's policies for detecting fraud, waste, and abuse

F. Pertaining to state laws, civil or criminal penalties for false claims and statements, DHMH policy includes the following language:

Under the Maryland Medicaid Fraud statute (see Md. Code Ann., Criminal Law §§ 8-508 to 8-517), a person who knowingly and willfully:

1. defrauds or attempts to defraud a State health plan in connection with the delivery of or payment for a health care service, or
2. obtains or attempts to obtain by means of a false representation any thing of value in connection with the delivery of or payment for a health care service through a State health plan, is guilty of a crime and is subject to imprisonment, a fine, or both; and is liable to the state for a civil penalty of up to three times the amount of the overpayment

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Civil Monetary Penalty Law

The Law Defined

Civil Monetary Penalty Law (CMPL)
Title 42 of the United States Code
(USC) Section 1320a-7a

The CMPL allows the DHHS OIG to impose monetary fines and assessments for a number of unacceptable practices, e.g.:

1. Submitting False Claims
2. Accepting Kick-Backs
3. Offering or providing inducements to Medicare and Medicaid beneficiaries to influence their choice of a Medicare or Medicaid provider

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Key Elements

A. The OIG is authorized to seek different amounts of CMPs as well as assessments according to the type of violation.

For example, in a violation of the FCA, the civil penalty can include:

1. $5,500 to as high as $11,000 for each item or service improperly claimed
2. And the assessment - up to three times the amount improperly claimed

B. In a violation of the AKB law, the:

1. OIG may seek a penalty of up to $50,000 for each improper act; and an assessment up to three times the amount of remuneration;
2. Administrative remedies can include:
   a. Exclusion from federal and state health care programs and listing on the LEIE and Maryland Sanctioned Providers List; or
   b. Government imposed compliance program

Anti Kickback Statute (AKB)

The Law Defined

Title 42 of the United States Code (USC) Section 1320a-7b

The statute makes it a criminal offense to "knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program such as Medicare or Medicaid. Remuneration is not limited to cash payments for referrals.

Key Elements

A. If anything of value is exchanged:
   such as referral fees, payment of travel and/or conference expenses, tickets to sporting events, free or below market value rental space between a referral source (e.g., physician) and a party who provides items or services covered by Medicaid or Medicare, then the AKB is implicated.
B. So, who's on first base in dealing with violators of the AKB?:
   1. The DOJ prosecutes "criminal" ADKB cases.
   2. The OIG has civil authority to exclude from Medicare and Medicaid programs provider who has participated in kickback scheme but has not been convicted under the criminal AKB statute.

Return to the Health Care Laws Menu

Physician Self Referral Act

The Law Defined

Physician Self Referral Act (Stark Self Referral Law) also known as (The Stark Law)
Title 42 of the United States Code (USC) Section 1395nn

Key Elements

1. Enacted in 1995, the Stark legislation was sponsored by Congressman Pete Stark of California in 1989
2. It prohibits a physician from referring Medicare and Medicaid patients for certain Designated Health Services (DHS) to entities in which:
3. the physician; or
4. their Immediate family member has a financial relationship unless an applicable exception applies
5. It also prohibits the Designated Health Services (DHS) provider from billing for any services rendered or goods delivered as a result of a prohibited referral
6. It ensures the physician's decision to refer is based on the best interest of the patient and not the physician's financial interest in the entity that provides the service or goods.

Continue

Physician Self Referral Act

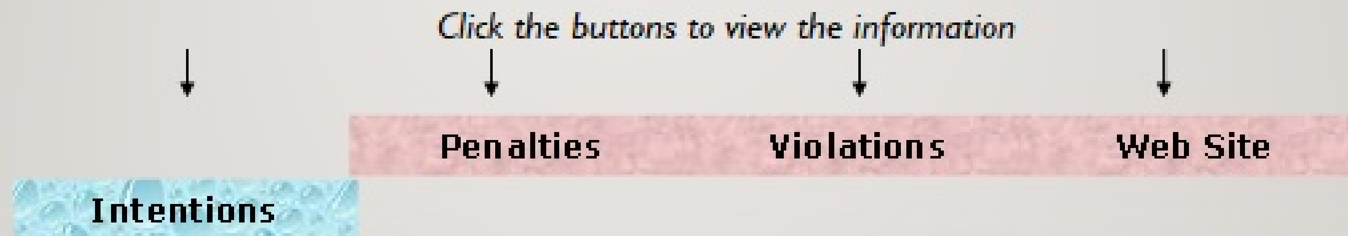
The definition for DHS is found in the Code of Federal Regulations (CFR) Title 42 Section 411.351

Designated Health Services include:

a. Clinical lab services;
b. Physical therapy;
c. Occupational therapy and speech pathology;
d. Radiology and certain other imaging services;
e. Radiation therapy and supplies;
f. Durable Medical Equipment (DME) and supplies;
g. Parenteral and enteral nutrients, equipment and supplies;
h. Prosthetics, orthotics and prosthetic devices and supplies;
i. Home health services;
j. Outpatient Rx drugs; and
k. Inpatient and outpatient hospital services.

Continue

Physician Self Referral Act - Intentions

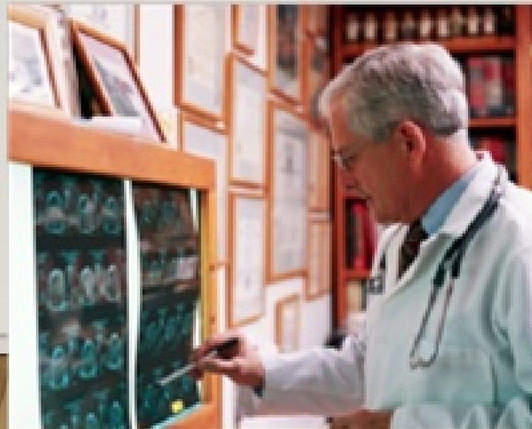


The Stark Law is intended to eliminate:

a. Conflicts of Interest where the physician could benefit through self- referrals

b. Over-utilization of services that could increase health care costs as the result of self referrals

c. The creation of a captive referral system that limits competition from other providers



Physician Self Referral Act - Penalties

Click the buttons to view the information

The penalties include:

1. Denial of payment for services resulting from a prohibited referral;
2. Refund of any payment made by the CMS to an entity furnishing DHS as a result of a prohibited referral;
3. A CMP of up to $15,000 per service plus an assessment of not more than three times the amount claimed
4. A CMP of up to $100,000 for circumvention schemes
5. A CMP of not more than $10,000 per day for failure to comply with reporting requirements
6. Program exclusion
7. Potential prosecution under the FCA

Physician Self Referral Act - Violations

Click the buttons to view the information

Potential Violations of Stark Law, or "What to look for" include

1. Is there a financial relationship between the physician (or immediate family member) and the entity providing the DHS services?
2. If yes, does the physician make referrals to the entity for DHS?
3. If yes, are the services payable or paid by Medicare or Medicaid?
4. If yes, do any of the Stark statutory exceptions apply? (See CFR Title 42, section 411.355 - 357)
5. If yes, does the arrangement meet all of the qualifications of the applicable exception?

Physician Self Referral Act - Web Site

Click the buttons to view the information

Intentions Penalties Violations

Web Site

For more information on the Stark Law

you can visit the CMS website at

www.cms.hhs.gov/PhysicianSelfreferral/

CMS Centers for Medicare & Medicaid Services

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Orally or in writing

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https://health.maryland.gov/oig/Pages/Report_Fraud.aspx

Please continue to the quiz by clicking the below link:
https://www.surveymonkey.com/r/7XVCCRM
You will be redirected to a new window.

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