WHAT ELSE CAN GO WRONG?
A REVIEW OF SOME OF THE MOST COMMON AND MOST DANGEROUS COMPLIANCE MISTAKES BY OPHTHALMOLOGY PRACTICES

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Financial Disclosure

- We are partners in the Washington, D.C. office of Arnold & Porter LLP.

Mini-Quiz: True or False:

- The Anti-Kickback Statute prohibits providing anything of value to induce a referral for services provided by a federal healthcare program
- Optometrists refer patients to ophthalmologists
- There is no “minimum amount” that is protected under the Anti-Kickback Statute

RELATIONSHIPS WITH OPTOMETRISTS
How Many Of You . . .

- Provide any form of education to your referring ODs
- Provide perks to referring ODs
  - Take them to dinner
  - Give them holiday gifts
- Lease Space, Equipment or Staff from an OD
- Co-manage with ODs
- Have an OD as an equity owner in your ASC

Providing Education to ODs

- Question if Government would challenge the provision of education alone, which is in the public’s interest
- Concern when more than education is included:
  - Provision of CE credits
  - Dinner during the education session -- and what is served
  - Provided in a resort during a weekend
- Limited to referring ODs
  - Although opening it up to all ODs has its risk as well
- Bigger concern when sponsored by industry
- Is there a better way?

Provide Perks to ODs

- Taking an OD to dinner
  - Where are you going - - Olive Garden or Le Cirque?
- Taking an OD to a sports event
  - Grandstand at Toledo Mud Hens or luxury box at the Dallas Cowboys
- Holiday gifts
  - Modest fruit basket to all, or differentiate based on the number of referrals

Lease Space, Equipment or Staff from ODs

- Do:
  - Written lease describing all you are leasing and when
  - Exclusive use
  - At least a year
  - Fixed, fair market value payment
- Don’t:
  - Base payment on the number of patients or per use
  - Allow the OD to use it when you are not there
  - Increase or decrease during the term based on need
Co-Management with ODs: Quiz

- Are patients referred to your practice for surgery from optometrists?
- Do you typically co-manage these patients?
- Do you have a written agreement with the co-managing OD that you will return patients for post-operative care?
- If you co-manage refractive services, do you pay the OD for the post-operative care?

Co-management with ODs, con’t

- Keys for Compliant Co-management
  - No agreement to refer - but protocol is fine
  - Assure patient choice, and document it
  - For non-covered services, ideal if the patient pays the OD directly, but at a minimum, the patient must know how much is for the OD’s services
  - Any payment to the OD must reflect fair market value
  - Be aware of State law requirements
    - See, e.g., Florida, Nevada laws addressing co-management

OD as an Equity Partner in an ASC

- Despite concerns, many ASCs have ODs as equity owners
- Key is to follow as many of the requirements for the ASC safe harbor as possible
  - E.g., fair market value payment, no discrimination on the amount of investment based on the amount of referrals, distribution made on the basis of equity, etc.
- Risk will be reduced further if it can be shown that the OD and MD have a long-standing referral relationship
- Risk will be heightened if the offer of an opportunity to invest is designed to change the OD’s referral pattern to the MD partner in the ASC
- And risk will be higher still if the OD is told to change the OD’s referral pattern and after a year the OD will be offered an opportunity to invest
The List No One Wants To Be On

- After attending a Compliance lecture at the 2016 ASOA meeting, you decided you had better implement a Compliance program. Since one of the elements of a program requires that you screen all of your employees against the OIG Exclusion List, you direct your office manager to go onto the OIG website to confirm that all of your employees are OK. Unfortunately, the name of one of your ophthalmic techs who has been with you for 2 years shows up.

Which of the following are possible?

- It was a false alarm; turns out when you checked the social security number, it was a different person.
- You confirm it is correct, but your tech explains that it took place 7 years ago, and she was excluded only for 3 years, so that ended before you hired her. You breathe a sigh of relief and do nothing since you have no exposure.
- You confirm it is correct, and make a voluntary disclosure to the OIG. Since you came forward voluntarily, the OIG thanks you for your honesty, congratulates you for being vigilant, and sends you off with a simple warning to be more careful in the future.
- You confirm it is correct, make a voluntary disclosure to the OIG and are offered a settlement to pay an amount equal to double the tech’s salary plus benefits you paid during the 2 year employment, multiplied by the percentage of federal health care patients in your practice.
- You kick yourself for going to that Compliance presentation and listening to that stupid lawyer.

Other Considerations About the List

- Don’t think that ignoring it is a better option
  - The penalties are far greater if the OIG finds out from someone else.
- Checking the list is not a one-time obligation
  - Some programs require monthly screening
- If you find that an employee is on the list, the employee must stop providing services to federal program patients
- Don’t think you are okay if you ask every employee to certify that they are not on the list.
  - It is still your responsibility to check the list.
- With the new repayment regulations, the risk of ignoring what you found has increased significantly.
Physician Compensation and the Stark Law

- A Practice is undergoing a due diligence review by a Prospective Buyer. One issue under review is compensation paid to employed physicians. The Practice pays employed physicians a guarantee plus a percentage of revenue from billings generated by the physicians, e.g., office visits, surgery, and diagnostics, such as OCT (based on the global fee payment). The Prospective Buyer advises the Practice that there is a problem in the compensation method, and will not proceed unless the Practice makes a voluntary disclosure.
- Is the Buyer correct? Why, or why not?
- If the Practice must make a voluntary disclosure, what does that mean?

Documentation Errors

- OMIC Survey
  - Majority of claims relate to cataract surgery.
  - Documentation may be the difference between showing a maloccurrence versus malpractice.
- Failure to document elements of the exam
  - Dilated retinal exam in patients who later experienced retinal detachments.
Documentation Errors

- **Telephone Care**
  - After-hours call from patient s/p LASIK with c/o of red, irritated eyes. Patient advised to use drops for dryness. Second call several days later for worsening symptoms, same advice. Developed infection and corneal ulcer. No records of calls or an operative note. Surgeon felt there was no need for the documentation for uncomplicated refractive surgery.

- **EHR Issues**
  - Pre-population of fields with normal findings and carry forward of previous exam require that you review and make changes to the record.
  - IOM has coined the term “e-iatrogenesis” defined as patient harm caused at least in part by the application of health information technology, most frequently inaccurate or incomplete data upon which clinical decisions are made.

Refractive Packages

- Two-Aspect Rule versus Non Covered Services versus Not Medically Necessary
- Paying for Services versus Paying for Outcomes
- Packages that include services rarely performed
- Marketing materials, informed consent, fee information, and staff explanations that are not consistent and are difficult to understand

Refractive Packages

- Review your packages critically to assure patients are paying only for items that fit into the two-aspect rule carve-out, or that are not covered by Medicare or that are not medically necessary for a patient undergoing cataract surgery.
- Be clear in your discussions with patients and in any written materials for what services the patient is paying and to whom (physician or facility).
- Have a third-party (preferably someone without extensive ophthalmology background) review all of your related materials and explain to you what they understood them to say.
- Consider a video, slide deck or at least a standardized script for staff to use when speaking with patients. Audit what is being told to patients.
Repayment of Overpayments

Pay back the $1500. You have an obligation to refund known overpayments and that is the amount that you know for sure is an overpayment.

Pay back $50,000. The audit confirms that you were overpaid for a particular procedure, so you know you have been overpaid by that amount.

Perform a complete review of your billing for this procedure for the prior 6 years and pay back the amount determined to have been overpaid.

Tell your billing manager that she no longer can go to the ASOA meeting.

The 2010 ACA provided that failure to refund an overpayment to the Medicare program within 60 days of identification of that overpayment triggers False Claims Act liability.

Final regulation published February 12, 2016

- Provider must conduct “reasonable diligence” once the provider has credible information of a potential overpayment
  - Reasonable diligence should take no more than 6 months
  - Credible evidence covers a wide range of sources, including government audits, external coding audits, internal employee concerns, etc.
- Provider has 60 days to make payment (or notify Medicare) once the overpayment amount calculated
- Required to go back 6 years
RELATIONSHIP BETWEEN PHYSICIANS AND INDUSTRY