Regulations that Affect Billing Compliance

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Stark (Physician Self-Referral Law)

Summary: Stark Law prohibits referring a Medicare patient for any health service to an entity which the provider (or an immediate family member) has a financial interest unless an exception applies. The entity that receives a prohibited referral may not bill Medicare for services performed. The original Stark Law (Stark I) was enacted in 1989 and basically referred to clinical laboratory services. In 1993, Congress broadened the Stark law (Stark II) to include referrals of a broad array of health services. Click here to access information from CMS on **Stark**

False Claims Act

Summary: The False Claims Act 31 U.S.C. sec. 3729-3733, protects the federal government against fraud and abuse. Under the False Claims Act (FCA), anyone who knowingly submit, or causes another person or entity to submit, or knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approval of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

The term "knowingly" means that a person:

1. Has actual knowledge of the information;
2. Acts in deliberate ignorance of the truth or falsity of the information; or
3. Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

The FCA contains qui tam, or whistleblower, provisions which allow anyone with evidence of fraud to sue on behalf of the government, in order to recover overpayments of federally funded health care programs. The Department of Justice can investigate and decide whether to join the action. If the government elects not to intervene, the qui tam relator may proceed with the action. The whistleblower may be awarded a percentage of the recovered funds.

For further details, access Department of Justice resources on the False Claims Act, click on the link(s) below :

False Claims Act Title 31
OIG Guidelines for Evaluating State False Claims Acts

Anti-Kickback Statute

Summary: The federal anti-kickback law's main purpose is to protect patients and federal health care programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal healthcare business, including Medicare and Medicaid, can be held accountable for a felony. Click here to access: **OIG Anti kickback Law and Safe Harbor Regulations Fact Sheet**

Antidumping Bulletin

SUMMARY: Special Advisory Bulletin addressing requirements of the patient anti-dumping statute and the obligations of hospitals to medically screen all patients seeking emergency services and provide stabilizing medical treatment as necessary to all patients, including enrollees of managed care plans, whose conditions warrant it. Click here to access full: **antidumping bulletin**

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Office of Inspector General (OIG) Compliance Guidance

The OIG has a list of compliance program resources for hospitals, physician practices, pharmaceuticals, third-party medical billing, etc. Click here to access: **OIG - Compliance Guidance**

Supervising Physicians in Teaching Settings

Summary: Section 15016, Supervising Physicians in Teaching Settings, was revised to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues and update regulatory references. Click here to access: **Supervising physicians in teaching settings**

The Quality Coding, Audit & Education Office is a central resource in promoting education and monitoring regulatory compliance for medical documentation, coding and billing. The Office assists in identifying and eliminating potential risk areas by activities which includes but is not limited to; providing education and training on regulations from Federal, State and other regulatory agencies affecting professional billing; conducting compliance validation reviews; recommending any needed changes or additions to billing policies and procedures; researching inquiries concerning proper billing practices; review, investigate and respond to reports of potential non-compliance; and recommending remedial actions for non-compliance.

Do you have any questions or concerns that are not answered on this site? Would you like to be notified when this site is updated?
Email us: **audit.ed@cumedicine.us**

The Audit, Compliance & Education Office is happy to assist in researching answers to your frequently asked questions. Below are past Q&A that were submitted to our office. In the FAQ section of the page are several links to valued resources pertaining to coding and billing questions. Please feel free to submit any questions you would like to see answered to our offices or email to **audit.ed@cumedicine.us**.

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