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Idaho Fraud and Abuse Statutes: Requirements, Penalties and Repayments

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Most Idaho healthcare providers are—or should be—aware of federal fraud and abuse laws, including the False Claims Act, Anti-Kickback Statute, Ethics in Patient Referrals Act ("Stark"), and the Civil Monetary Penalties Law, but they may not realize that Idaho has its own fraud and abuse laws that also apply. Violations may result in criminal, civil, and administrative penalties in addition to the obligation to repay amounts received in violation of the rules and provider agreement.

1. Idaho Anti-Kickback Statute. It is illegal for a health care provider to engage in the following misconduct:

> (1)(a) Knowing that the payment is for the referral of a claimant to a service provider, either to accept payment from a [healthcare] provider or, being a [healthcare] provider, to pay another; or
>
> (b) To provide or claim or represent to have provided services to a claimant, knowing the claimant was referred in violation of paragraph (a); [or]
>
> (2) [E]ngage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give or pay all or part of a claimant's deductible or claim for casualty, disability insurance, worker's compensation insurance, health insurance or property insurance.

(Idaho Code § 41-348). The statute applies to referrals for "health care services", which are defined as "a service provided to a claimant for treatment of physical or mental illness or injury arising in whole or substantial part from trauma." (*Id.* at § 41-348(2)). Violations may result in civil monetary penalties of up to $5,000. (*Id.* at §§ 41-348(4) and 41-347(1)). Significantly, the Idaho statute is broader than its federal counterpart: it applies to services payable by private payers as well as government programs.

Provider licensing acts may also implicate kickback situations. For example, physicians may be disciplined for:

> (8) Division of fees or gifts or agreement to split or divide fees or gifts received for professional services with any person, institution or corporation in exchange for referral.
>
> (9) Giving or receiving or aiding or abetting the giving or receiving

of rebates, either directly or indirectly.

(Idaho Code § 54-1814). Violations may result in adverse licensure action, fines or other sanctions.

2. Medicaid Fraud and Abuse. Participation in Medicaid exposes providers to significant penalties for a broad range of misconduct ranging from fraud to the mere failure to comply with Medicaid rules or provider agreement terms.

1. **Medicaid Fraud.** Under the Medicaid statute,

   Whoever knowingly obtains, or attempts to obtain, or aids or abets any person in obtaining, by means of a willfully false statement or representation, material omission, or fraudulent devices, public assistance to which he is not entitled, or in an amount greater than that to which he is justly entitled, shall be punished in the same manner and to the same extent as for larceny or theft of the money or value of the public assistance so obtained or attempted to be so obtained.

(Idaho Code § 56-227(1)). In addition, it is a felony for:

> any provider or person, knowingly, with intent to defraud, by means of a willfully false statement or representation or by deliberate concealment of any material fact, or any other fraudulent scheme or device, to:
>
> (a) present for allowance or payment any false or fraudulent claim for furnishing services or supplies; or
>
> (b) attempt to obtain or to obtain authorization for furnishing services or supplies; or
>
> (c) attempt to obtain or to obtain compensation from public funds greater than that to which he is legally entitled for services or supplies furnished or purportedly furnished.

(*Id.* at § 56-227A). A provider engaging in Medicaid fraud may also be subject to civil damages:

> Any provider who knowingly with intent to defraud by means of false statement or representation, obtains compensation from public funds greater than that to which he is legally entitled for services or supplies furnished or purportedly furnished shall be liable for civil damages equal to three (3) times the amount by which any figure is falsely overstated.

(*Id.* at § 56-227B).

2. **Prohibited Self-Referrals.** The federal Stark law prohibits physicians from making referrals for certain designated health services payable by Medicare or Medicaid to entities with which the physician, or the physician's family member, has a financial

relationship unless the transaction is structured to fit within a regulatory safe harbor. (42 USC § 1395nn; 42 CFR § 411.353). Idaho does not have its own version of Stark; however, Idaho Medicaid regulations allow DHW to "deny payment for any and all claims it determines are for items or services … provided as a result of a prohibited physician referral under [Stark,] 42 CFR Part 411, Subpart J." (IDAPA 16.05.07.200.01). The net effect is that a Stark law violation may result in penalties and repayments under Idaho law as well as federal law.

3. **False Claims.** The Idaho Department of Health and Welfare may impose civil penalties against a Medicaid provider who:

> (a) Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item and amount is specifically identified; or
>
> (b) Submits a fraudulent claim; or
>
> (c) Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the department; or
>
> (d) Submits a claim for an item or service known to be medically unnecessary; or
>
> (e) Fails to provide, upon written request by the department, immediate access to documentation required to be maintained; or
>
> …
>
> (i) Has been found, or was a "managing employee" in any entity that has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care or public assistance items or services….

(Idaho Code § 56-209h(6); *see also* IDAPA 16.05.07.230).

4. **Failure to Comply with Medicaid Rules or the Provider Contract.** Section 56-209h not only applies to knowingly fraudulent or abusive conduct; it also subjects providers to repayment or other penalties for failing to follow Medicaid rules or provider contract terms, *i.e.*, if the provider:

> (f) Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments or other public assistance program payments; or
>
> (g) Knowingly violates any material term or condition of its

> provider agreement; or
>
> …
>
> (j) Fails to meet the qualifications specifically required by rule or by any applicable licensing board.

(Idaho Code § 56-209h(6); *see also id.* at § 56-209h(5)). Medicaid regulations also allow the Department to deny payment for the following reasons:

> **01. Billed Services Not Provided or Not Medically Necessary.** The Department may deny payment for any and all claims it determines are for items or services:
>
> a. Not provided or not found by the Department to be medically necessary.
>
> b. Not documented to be provided or medically necessary.
>
> c. Not provided in accordance with professionally recognized standards of health care.
>
> ….
>
> **02. Contrary to Rules or Provider Agreement.** The Department may deny payment when services billed are contrary to Department rules or the provider agreement.

(IDAPA 16.05.07.200).

The current Medicaid provider agreement requires providers to comply with a broad range of statutes and rules, the violation of which might subject providers to penalties under Idaho Code § 56-209h. For example, the provider agreement requires providers to comply with the following:

> **1. Compliance.** To provide services in accordance with all applicable federal laws, and provisions of statutes, state rules, and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including [IDAPA Medicaid regulations]; the current applicable Medicaid Provider Handbook; any Additional Terms attached hereto and hereby incorporated by reference; and any instructions contained in provider information releases or other program notices….
>
> **2. Provider Information.** To provide true and accurate information on the Enrollment Request form, Enrollment Attachment …, Disclosure Statement and all supporting documentation….
>
> **3. Professionalism.** To be licensed, certified, or registered with the appropriate state authority and to

provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally supervised paraprofessionals where their use is authorized….

4. Recordkeeping. To document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h(3), as amended, applicable rules, and this Agreement. Such records shall be maintained for at least five years after the date of services or as required by rule….

5. Accurate Billing. To certify by the signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Department rules, and this Agreement. The provider further agrees:

5.1 To be solely responsible for the accuracy of claims submitted, and … immediately repay the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed.

5.2 To assure that a duplicate claim under another program or provider type is not submitted.

5.3 To bill only for services delivered by individuals who are not on any state or federal exclusion or disbarment list and have the qualifications required for the type of service that is being delivered.

6. Secondary Payer. To acknowledge that Medicaid is a secondary payer and to seek payment first from all other sources as required by rule, regulation, or statute, before billing Medicaid….

7. Payment. To accept Medicaid payment for any item or service as payment in full and to make no additional charge except that specifically allowed by Medicaid….

8. Service Providers. … The Provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

(Idaho Medicaid Provider Agreement (06/11), available here).

5. **Failure to Grant Immediate Access.** Idaho Code§ 56-209h(e)

allows the Department of Health and Welfare to impose penalties against a provider who "[f]ails to provide, upon written request by the department, immediate access to documentation required to be maintained. (Idaho Code § 56-209h(6)). The corresponding regulations confirm that "[t]he Department may deny payment when the provider does not allow immediate access to records as defined in Section 101 of these rules." (IDAPA 16.05.07.200).

6. **Failure to Repay Overpayments.** Medicaid providers have an affirmative obligation to "immediately repay the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed." (Medicaid Provider Agreement § 5.1). Under the Medicaid statute, penalties may be imposed against a provider who:

   > Has failed to repay, or was a "managing employee" or had an "ownership or control interest" in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation or provider agreement.

   (Idaho Code § 56-209h(h)). Unlike the federal regulations, there is no specified deadline or process for repayments owed to Medicaid. Based on informal discussions with the Idaho Medicaid Fraud and Program Integrity Unit, Medicaid generally does not charge interest if repayment is made within 60 days. In appropriate circumstances, Medicaid has generally allowed providers up to one year to repay, but has charged interest on the repayment. Repayment is usually made to the Medicaid Program Integrity Unit. The statute does not contain a materiality limit, nor does it contain an express "lookback" period; however, as a general matter, the Medicaid Program Integrity Unit only goes back five years in its audits.

7. **Penalties.** Violations of the Medicaid fraud and abuse statute may expose the provider to the following penalties, depending on the circumstances:
   a. Immediate suspension or withhold of payments if Medicaid has identified a suspected case of fraud or abuse and has reason to believe that payments made during the investigation may be difficult or impractical to recover. (Idaho Code § 56-209h(4)).
   b. Recovery of payments if Medicaid determines that any condition of payment contained in rule, regulation, statute, or provider agreement was not met. (*Id.* at § 56-209h(5)).
   c. Civil monetary penalties of up to $1000 per violation. (*Id.* at § 56-209h(8)).
   d. Termination or suspension of the provider agreement. (*Id.* at § 56-209h(4)).
   e. Exclusion from participation state programs, which in turn may result in exclusion from federal programs. (*Id.* at § 56-209h(10)).
   f. Referral to the Idaho Medicaid Fraud Unit for further action.

3. Insurance Fraud. Penalties may also be imposed against a provider who engages in fraudulent conduct with private payers. Insurance fraud is generally defined as:

> Any person who, with the intent to defraud or deceive an insurer for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, producer, practitioner or other person, any statement as part of, or in support of, a claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim;

(Idaho Code § 41-293(1)(a)). Such a person:

> is guilty of a felony and shall be subject to a term of imprisonment not to exceed fifteen (15) years, or a fine not to exceed fifteen thousand dollars ($15,000), or both and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section. Each instance of violation may be considered a separate offense.

(*Id.* at § 41-293(4)).

As an alternative to criminal penalties, providers who violate their managed care or other third party payer contracts may also be subject to breach of contract claims and exclusion from participating provider panels.

Conclusion. In many ways, the Idaho fraud and abuse statutes are broader and potentially more dangerous than their federal counterparts. Providers should ensure that they understand their obligations—especially obligations in Medicaid regulations and the Medicaid provider agreement—then take appropriate steps to maintain compliance. As with anything in healthcare, an ounce of prevention is worth a pound of cure or, in this case, a pound of penalties.

For questions regarding this update, please contact:
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