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Medicaid anti-fraud units becoming all-purpose enforcers

MFCUs now targeting pharmaceutical pricing, long-term care, and medical records privacy

Medicaid Fraud Control Units (MFCUs) are becoming all-purpose health care enforcers, partnering with government agencies at all levels to combat fraud. "These networks have been established, and they are not going to go away," warns **Ellyn Sternfield**, director of the Oregon Medicaid Fraud Control Unit in Portland.

Today, all but three states — Idaho, North Dakota and Nebraska — have active MFCUs. MFCUs typically follow the lead of the state Attorney General's (AG) Office, where most are housed. According to Sternfield, that makes pharmaceuticals, long-term care (LTC), and medical records high-priority items for most of those units.

Ironically, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 poured money into nearly everyone's coffer except the MFCUs'. The Federal Bureau of Investigation (FBI), HHS Office of Inspector General (OIG), and U.S. Attorneys Offices all received a major infusion of cash to target health care fraud. What the MFCUs got was improved coordination on billing fraud and patient abuse cases at the national, regional, state, and local levels.

Gone are the turf wars of the past, says Sternfield. Today, U.S. Attorneys routinely turn to MFCUs to see if there is a Medicaid program

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Pharmaceuticals become hot-button for investigators

The next major target of health care anti-fraud enforcement efforts is going to be pharmaceuticals, warns **John Bentivoglio**, former Justice Department fraud chief now with Arnold and Porter in Washington, D.C. **James Sheehan**, Assistant U.S. Attorney and civil chief of the Eastern District of Pennsylvania in Philadelphia, likewise predicts "there is a storm rising" in this area, and both agree that it is largely driven by the rising dollars now spent in this area.

According to **Carolyn McElroy**, who until recently was the head of the Maryland Medicaid Fraud Control Unit (MFCU), there is no shortage of issues

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Integrate physicians to prevent *qui tam* suits

Most physician-related government investigations are not triggered by carrier or intermediary audits, but by complaints made by employees or competitors, says **Dan Roach**, vice president and corporate compliance officer for Catholic Heath Care West in San Francisco. "Every investigation that I have been involved in at two large health care settings has been the result of somebody going to the government and complaining about conduct within the organization," he reports.

Expect that trend to continue. **Marc Raspanti** of Miller, Alfonso & Raspanti in Philadelphia, says there's been a 100% increase in the number of physicians who are willing to blow the whistle on hospitals, competitors, and HMOs. "Physicians are tired of being beaten up, and they are increasingly willing to fight back," he asserts.

According to Roach, individual physicians and health systems that employ them can dramatically reduce their exposure if they understand that fact

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impact on their investigations, and when the Department of Justice gets notice of a *qui tam* filing, it does the same.

"There is a lot more cooperation and coordination on health care fraud than there ever used to be," Sternfield says. It is now standard practice for a task force to include representatives from the OIG, FBI, U.S. Attorney's Office, and the state Medicaid agency and Medicare carrier.

On one hand, that means more resources and a more coordinated attack aimed at providers because it allows all these players to pool their resources and discover any weaknesses in their case. "It may be daunting to face that on the defense side," says Sternfield. "But on the positive side, you are dealing with everybody at once, and you are not going to have to worry about a piecemeal attack."

About a year ago, the jurisdiction of these units was expanded to include billing fraud against any federally funded health care program as long as the fraud started with Medicaid. Their domain also was expanded to include residents of any LTC facility, as long as it is a residential setting where two or more unrelated persons pay for their housing and receive some assistance with their activities of daily living.

MFCUs mainly are reactive and differ state to state, according to Sternfield. "There are as many differences as there are MFCUs," she says. Part of the difference turns on state law, and part of it on the fact that most MFCUs are situated in the AG's office and, for the most part, follow the AG's lead.

In Mississippi, that means the MFCU is putting a high priority on patient abuse, much like the AG in that state. In Washington state, where the AG is emphasizing multistate cases, the MFCU is taking a large role in a number of national cases.

That said, Sternfield says there are several issues that currently cut across nearly every state:

♦ **Pharmaceutical pricing.** "The overriding hot-button in nearly every state right now is pharmaceutical pricing," asserts Sternfield. The reason: Medicaid pharmaceutical costs have skyrocketed and, unlike Medicare, Medicaid programs cover at least some pharmaceutical costs. In Oregon, for example, increased cost pharmaceuticals were a major reason the state's Medicaid budget leaped from $1.5 billion in 1996 to $2.3 billion in 2001. **(See related story on pharmaceutical fraud, page 1.)**

♦ **Long-term care.** Look for MFCUs to continue pursuing quality-of-care cases against LTC facilities, Sternfield warns. But she adds that most units focus not only on abuse and neglect, but whether the facility committed fraud by billing for a level of services not actually provided to residents.

On a more positive note, she predicts that more and more states will retreat from the "aging in place" doctrine, which holds that one LTC setting can meet all of a senior's needs even as those needs change. "How fair is it for the MFCUs to look at an assisted living facility for some violation of law for failing to provide services when three years earlier, the facility could have predicted they would not be able to that level of care," Sternfield argues.

Other concerns in LTC include "wave" therapy by ancillary providers where therapists barely see a resident but then bill for providing a comprehensive service.

♦ **Managed care.** The notion that no fraud exists in managed care is dead, Sternfield says. While nobody knows exactly what direction ongoing investigations may take, she says MFCUs are

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looking at the use of unqualified providers and underutilization as well as the fiscal integrity of managed care organizations.

Medicaid and Medicare enrollment projections have fallen far short of original expectations, but many states, including Tennessee, Arizona, New York, and California still have high managed care penetration, she notes.

♦ **Medical records privacy.** Regardless of what happens at the federal level, Sternfield says at least eight state legislatures are revamping their rules governing medical records privacy. She says the enforcement nightmare that may flow from that fact is very problematic.

"Can you imagine what is going to happen if we have 50 different standards of medical records privacy?" she asserts. "If the feds don't act, the states are going to act, and this is going to be a political issue." ■

Physician *qui tam*

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and establish effective mechanisms that address employee concerns, perform basic audits, and promptly refund overpayments. Even modest efforts at compliance will reduce *qui tam* suits, agrees Raspanti, who is one of the most successful *qui tam* attorneys in the country. "Ignoring the problem is no longer an option," he warns.

Debbie Troklus, a manager with Price WaterhouseCoopers in Louisville, KY, says a risk-based assessment conducted by the practice often will identify other areas that are high risk and need policies developed to minimize that risk.

Like Roach, Troklus says the best place to start is the OIG's guidance for physicians and small practices. "That gives several hot areas that should guide you in risk assessment and policy development," she asserts. "The guidance identifies risk areas for both billing and coding."

"A few policies and procedures that I would suggest are record retention, credit balance, nonretaliation/nonretribution," adds Troklus. "Developing policies and procedures should be a fluid process and could save your practice a lot of needless mistakes."

Here are several areas Roach says doctors and hospitals should focus on:

♦ **Documentation.** Roach tells physicians the three most important things are documentation, documentation, and documentation, with specific attention focused on basics such as making sure that legible medical records include the reason for the encounter, diagnostic test results, and plan of care, as well as the date and a legible identity including signature.

None of that is new to physicians, and they often get tired of hearing the same message, he warns. But once they understand the implications that documentation has on payment and quality of care reviews, they begin to understand its importance, he adds.

For example, Roach says patients now visit numerous web sites to gauge the quality of hospital services in specific areas such as oncology and cardiac care. "Physicians should understand that minor changes in behavior can make a real difference in how they fare and that documenting complications and comorbidities can have a real impact on how the hospital scores," he explains.

♦ **Anti-kickback.** "This is the year of the kickback investigation," predicts Raspanti. He says that means doctors should re-evaluate their interaction with pharmaceutical companies and ancillary service providers, or else they may find that what was common practice not long ago is now perceived as criminal.

Roach agrees that physicians often fail to understand this area, even though kickbacks are covered by the OIG guidance. "The guidance helps them understand that they can be ethical and still not follow the anti-kickback laws," he says.

♦ **Reasonable and necessary services.** Roach says another important focus in the guidance is the distinction between tests that a physician might deem appropriate and Medicare's definition of reasonable and necessary. Even though the OIG attempted to help physicians understand the difference, this remains an area of "substantial confusion" for physicians, says Roach.

♦ **Education and training.** Hospitals also can use the guidance as a tool to help support physician education and help physicians understand their obligations. "One thing physicians rarely understand is that there is a federal criminal statute that makes it a crime to fail to disclose overpayments to the government," warns Roach. ■

Pharmaceutical fraud

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on the government's agenda, which already includes average wholesale price (AWP) and WAC reporting, kickbacks in promotions and marketing, and Medicaid rebate issues.

The problem is that enforcement is now substituting for regulatory leadership, argues McElroy, now with Mintz Levin in Washington, DC. In addition to a growing stream of *qui tam* suits, she says the U.S. Department of Justice, state Attorneys General, the Department of Health and Human Services' Office of Inspector General, and now Congress all have their hand in this pot.

The extent to which hospitals get caught up in this storm will turn partly on whether they have owned or managed medical groups, according to **Paul DeMuro** of Latham and Watkins in San Francisco. "If hospitals own or manage medical groups, they face the same issues as doctors who administer these drugs in their office," he explains.

DeMuro says the problem arises when the acquisition cost, AWP, or other pricing mechanism hospitals use to record price to the Medicaid program differs from the amount it bills Medicaid based on a fee schedule. "That is not enough to make it a crime," he explains. "But if the hospital had a group that it owned or managed, it could arguably be responsible for billings."

Meanwhile, MFCUs routinely handle cases that involve diversion of pharmaceuticals that often implicate hospitals to cases as simple as nurses stealing morphine and clerks calling in false prescriptions. ■

GAO: Justice Department has improved use of FCA

The Justice Department is doing a better job of following its own guidance on use of the False Claims Act (FCA), the General Accounting Office concluded in a new report. But the health care industry still sees the act as draconian, with some projections suggesting that 80% of all recoveries will come from *qui tam* suits. For more information on GAO's report, go to www.gao.gov.

See the next issue of Compliance Hotline *for circuit court cases that may help reign in the FCA and advice on best defenses.* ■

Novel defense overturns suspension of payments

When a small-practice physician in southern Florida had $170,000 in claims suspended based on allegations of services not provided, duplicate services, and altering records, **Gabe Imperato** and his colleagues at the law firm Broad & Cassel in Fort Lauderdale, FL, uncovered a novel defense.

Imperato, who specializes in this area, says that most challenges to suspension actions in federal court are thrown out. Because the dermatologist had a successful practice that derived roughly half his revenue from private-pay sources, the physician opted to challenge the suspension in part to avoid having the administrative action turn into a criminal or civil fraud action down the road.

In preparing the complaint, Imperato and his associates decided to challenge the suspension on a basis unrelated to any particular facts of the case. The theory of the case attorneys identified was that authority for the promulgation of suspension regulations (42.usc.13915y(d)), became effective in October 1972 and was repealed in 1987 with no statute ever enacted to replace it. The provision that replaced the existing statute addresses exclusion but not suspension, Imperato says.

"The theory was that there was no underlying authority for these suspension regulations; therefore, they should be stricken," he says. The physician filed a complaint, which was followed by the Secretary's "garden variety" motion to dismiss, Imperato reports. The Broad & Cassel attorneys then filed for injunctive relief, using memoranda that laid out their case. A week later, the Secretary returned the $170,000 and lifted the suspension.

"Either they did not want to risk challenge to their authority to even promulgate those regulations in a courtroom where it could become a matter of precedent and could be used nationwide, or they looked into the case and found that there was no reliable evidence of fraud or misrepresentation," says Imperato."

That particular legal circumstance still exists, he says. "We are constantly vigilant for the opportunity to roll out that argument in other cases," he says. "I don't know what the future holds." ■