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Government outlines blueprint for war on health care fraud

OIG and FBI say foci include kickbacks, long-term care, PPS, and the Internet

Expect the federal government's full-court press against health care fraud to continue unabated, as the Bush administration continues its predecessor's aggressive use of the False Claims Act (FCA).

"I don't think we are going to see any major sea change in the enforcement of the fraud and abuse laws," says **Lew Morris**, an attorney with the Department of Health and Human Services Office of Inspector General (OIG). Morris recently spoke at the Health Care Compliance Association conference in Washington, DC.

Fighting fraud has always been a nonpartisan proposition. For example, Sen. Charles Grassley (R-IA), the architect of the revitalized FCA, now heads the Senate Finance Committee. That gives him a powerful influence over the Department of Justice (DOJ) and the initiatives of the administration, Morris says. On top of that, Attorney General John Ashcroft already has pledged his strong support for the continued enforcement of the FCA.

Morris says the OIG will continue to work with the DOJ to support its FCA authorities as well as terminations, suspensions, and exclusions to address the delivery of poor care to beneficiaries and failure to provide care.

*See **Fraud blueprint**, page 2*

Circuit courts take aim at False Claims Act

It's no secret the False Claims Act (FCA) still is the weapon of choice for health care fraud investigators. The number of *qui tam* cases skyrocketed from 17 in 1992 to more than 300 in 1999, and more than $3 billion has been recovered by the government. But now the "punitive nature" of the FCA is coming under scrutiny by several circuit courts.

In March, a panel of the Ninth Circuit ruled that because FCA penalties and damages are punitive, they must be analyzed under the Eighth Amendment to determine whether they violate the Excessive Fines Clause of the Constitution.

*See **False Claims Act**, page 3*

OIG warns of anti-kickback statute role reversal

Mac Thornton, general counsel to the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), is warning hospitals that just because they can't effectively manage the physician practices they acquired in the mid-to-late 1990s does not mean they can simply turn those practices back over to physicians.

A few years ago, hospitals were acquiring physician practices, sometimes with "pumped up valuations for intangibles" such as good will or the value of patient records, Thornton told attorneys at the Practicing Lawyers Institute in New York City April 26. "A lot of them apparently paid too much, and now they want to get out," he adds.

Hospitals should view the risk of getting out of these agreements this way, Thornton says: If you paid X dollars seven years ago, and you sell the practice back for one-tenth of that, or even give it back for free, how is your valuation going to look?

*See **Anti-kickback statute**, page 3*

Fraud blueprint

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"In particular, we are focusing on long-term care facilities," he reports. But the DOJ and U.S. attorneys offices have been using the False Claims Act to address failure to provide care in psychiatric hospitals as well, he says.

Morris points out that the OIG has civil monetary penalty authority and exclusion authority not only for entities but also for individuals who provide subpar care. Since excluding an entire entity can have a negative effect on beneficiaries, the OIG plans to use its authority to target individuals, administrators, and owners who oversee the delivery of inadequate care, he says.

Another key target is kickbacks, Morris warns. The anti-kickback statute is a criminal statue, but in addition to criminal penalties, it includes an administrative sanction of $50,000 per incident plus treble damages, which allows the OIG to pursue people paying and receiving kickbacks. And the OIG plans to make the most of that authority.

"We will be looking for cases that DOJ and U.S. attorneys offices are not going forward with criminally to develop administrative responses," Morris reports. And to do that, he says, veteran attorneys with experience handling those cases are being added to the OIG's Office of Counsel.

Morris says another focal point is the expansion of benefits and conversion to the prospective payment system, which he says will require a "rethinking" of how the government identifies and develops fraud cases, because it changes many of the dynamics that underlie billing.

At the same conference, **Tim Delaney**, a supervisor in the Federal Bureau of Investigation's (FBI) Washington office, pointed out that health care fraud is one of the few white-collar programs to be classified as a Tier I program because it threatens the national economy.

Delaney says that's why the FBI employs the aggressive use of asset forfeiture and money. "We don't feel it is enough to catch somebody and convict them, even if they go to jail," Delaney says. "We want to take away their ill-gotten gains."

The bureau now has a dozen dedicated squads focused solely on health care fraud, which is now the top priority in two-thirds of the offices across the country and No. 2 in the remainder, he reports.

The result: The number of open and assigned cases has escalated from 591 in 1992 to more than 3,000. The success rate also has kept pace, with the number of convictions growing from 116 to 580 over the same period.

Delaney says the easiest targets still are services not rendered, upcoding, and billing for unnecessary services. Kickbacks also are a high priority, he adds, and the FBI is now lobbying to extend its reach to private insurance cases. "Right now. it is not illegal for two private insurers to pay each other kickbacks," he says.

Delaney says hospitals are being scrutinized for cost report fraud, billing for services not rendered, and kickbacks. Billing for less-qualified persons is another major target, he says.

Here are some other key targets, Delaney reports:

- **Home health care.** Investigators are scrutinizing unnecessary treatment plans, cost report fraud, billing for patients who are not really homebound, and billing unskilled services as skilled services.
- **Mental health facilities.** Key targets in these facilities include individual therapy billed as group therapy and upcoding the length of visits. "We had one case that we called 'wave therapy' because the psychiatrist would walk in and wave

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and then bill for a counseling session," says Delaney.

♦ **Nursing homes.** The FBI is working nursing home cases jointly with Health and Human Services, looking at kickbacks to administrators, cost report fraud, services not rendered, upcoding, and durable medical equipment (DME). One ongoing case involves the inclusion of personal expenses such as automobile for personal use in cost reports.

♦ **Clinic fraud.** Key targets in clinics include services not rendered, kickbacks to attorneys, and sending accident victims to certain clinics as well as kickbacks from laboratories and DMEs.

♦ **Transportation fraud.** The FBI provided other agencies with training in this area and now is reaping the fruits. Key targets: Inflating trip mileage reports, billing for nonmedical transportation, billing round-trip for one-way transportation, falsely billing patients as stretcher-bound, and billing advanced life support when only basic life support was provided.

Looking ahead, Delaney says the FBI is looking closely at how the Internet will shape health care delivery and the fraud that goes along with it. He notes that by 2003, 67 million people are expected to seek health care information on the Internet, and total Internet health care business is expected to increase from $400 million in 1999 to $22 billion in 2004.

Delaney says the FBI is zeroing in on where sites are located, what entity is actually behind an e-mail address or web site, as well as adequacy of services. "We want to look out for quackery on the Internet, bad medicine, and potential health risks," he concludes. ■

Anti-kickback statute

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Thornton says the principle here is the same as it was during the acquisition. That is, when you are dealing with a system with referral sources, the dealings must be based on "legitimate fair-market value." The challenge is how to price what the hospital will accept from the doctors to buy the practice back.

Thornton offers a couple of hints. First, hospitals should use the same method that was used in the acquisition and maybe even the same valuation expert. "If you paid a lot seven years ago for patient records or the good will patients have for the physician practice, you are going to have to pay for them now," he warns. "If you don't, someone like myself is going to ask about the valuation."

Those patient records and the good will of patients still have value, even if the hospital running the practice is losing money, Thornton asserts. "What was good in 1994 has to be good now," he cautions. ■

False Claims Act

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The Ninth Circuit cited the Supreme Court's language in last summer's *Stevens* case, in which the court said the current version of the FCA imposes damages that are "essentially punitive in nature." False Claims expert **John Boese** of Fried, Frank in Washington, DC, says Justice Antonin Scalia launched "a potentially revolutionary trend in FCA jurisprudence" when he called FCA damages "essentially punitive."

Boese notes that Scalia's language also was at the heart of a ruling recently issued by a panel of the Fifth Circuit Court of Appeals, vacating a $22 million FCA jury verdict against the Orleans Parish School Board.

While the Ninth Circuit affirmed liability, it had "obvious problems" with the penalty, explains **Patric Hooper**, of Hooper Lundy in Los Angeles. In fact, it ruled that both aspects of the FCA — treble damages and statutory penalties — are subject to review to determine if they are excessive, he notes. "Both have a punitive nature and neither one is purely remedial," he argues.

"The court has to decide which part is punitive and which part is remedial,"says Hooper. "The court has not said there is something wrong with it being punitive; it has just said that it is punitive." Unfortunately, the Ninth Circuit did not decide that issue but instead handed it back to the district court.

The Ninth Circuit case involved a physical therapy clinic that allegedly ran afoul of Medicare

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payment guidelines. The clinic was accused of bilking Medicare for $58,000 over five years. The trial court imposed damages of $730,000, even though that number could technically have run as high as several million, according to the statute.

Boese says the critical fact for private defendants in FCA cases is that two different circuit courts of appeal have reversed lower court decisions after concluding that the FCA's treble damages are punitive. "This is clearly a trend that must be followed carefully by all practitioners," he says. ■

Limit exposure by analyzing government fraud data

Government agencies, including the Health Care Financing Administration (HCFA) and the Department of Health and Human Services Office of Inspector General, often tout the dramatic reduction in Medicare's improper payment rate over the last four years — from 14% of program expenditures or $23 billion in 1996 to just under 7% or $11.9 billion last year — as evidence the government's war on health care fraud is paying dividends. Government and private sector experts say studying that statistic can help keep providers from becoming part of it.

Health care attorney **Thomas Coons**, of the Baltimore law firm Ober Kaler says the government can "slice and dice" these data in any manner, shape, or form to determine how providers compare in terms of their specialty, locality, or region. They can also determine the number of procedures and the utilization rate and whether there has been a spike that month or that year. "They can very easily take a snapshot of you that you would not believe," Coons asserts.

That's the bad news. The good news is that most of these data are publicly available, and providers can use these same data to perform a self-examination, says Coons. "It is very important to periodically engage in the same self-examination using the same resources HCFA has," he explains.

According to Coons, providers can often limit their exposure by examining the government's "data-rich" environment. He points out that the government regularly looks at provider-specific information including focused medical review reports, denial records, cost report data and provider billing files, and says that, wherever possible, providers should do the same.

In all, Coons cites 21 specific data elements the government examines, from new technologies and newer classified benefits to trend analysis of therapy providers and service frequency variation.

Understanding what to look for in the data also means understanding the type of violations the government is looking for, according to Coons. He lists no fewer than 25 examples of health care fraud, from incorrectly reporting a diagnosis or procedure and billing for services not rendered to billing for discharges in lieu of transfer and failure to refund credit balances in a timely fashion.

For example, to reduce cost-reporting problems, Coons says hospitals should look for consultant activity regarding maximization of costs and allocation of hospital costs to units that receive no benefit.

Once providers understand what the government is looking for and the data they are using to draw their conclusions, he says they should develop specific checklists of what to look for.

In the area of cost report fraud, Coons lists 16 potential problems ranging from incorrectly apportioning costs on cost reports and included costs for noncovered services to claiming depreciation methods not approved by Medicare and claiming interest expense for loans that have been repaid for an offset of interest income against the interest expense.

Coons' checklist covers specific areas of the cost report in areas ranging from 21 nonallowable or nonreimbursable items and activities to the improper treatment of capital costs. Other specific areas highlighted by Coons include:

- manipulation of cost centers;
- allocation of physician time and overhead;
- reserves;
- kickbacks;
- credit balances;
- Medicare Secondary Payer issues;
- bad-debt claims. ■