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Columbia suit highlights hospital vulnerabilities

Earlier this month, the other shoe dropped for the embattled health care chain Columbia/HCA. A federal district court judge in Tampa unsealed a *qui tam* lawsuit, filed by a former hospital CFO and joined by the Department of Justice, that could result in one of the largest settlements in the history of organized health care.

Besides its massive scope, the suit is significant because it offers a detailed look at how the federal government may prosecute other hospitals and chains based on allegations of fraudulent cost reporting.

Until now, hospital cost reports represented an arcane field that no one paid much attention to. But experts say the Columbia suit could provide a map for whistle blowers hunting smaller prey. Any hospital that maintains reserves against cost reports, or makes any mistakes in allocating expenses among a menagerie of confusing cost centers, could be hit with a false claims suit.

"This is going to be a big wave," says **Stephen Meagher**, JD, with the law firm Phillips and Cohen in San Francisco. Meagher represents James Alderson, the former CFO of North Valley Hospital in Whitefish, MT, who blew the whistle in the Columbia suit.

Meagher declined to estimate the value of the false claims Columbia allegedly made. But he acknowledged that a settlement in the case could exceed $1 billion. The suit also targets Nashville-based Quorom Health Resources and Healthtrust Inc., which Columbia acquired in 1995.

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Investigators crack down on state mental health centers

After uncovering $229 million worth of allegedly fraudulent Medicare claims from community mental health centers (CMHCs) in five states, federal investigators are pushing for Congress to dump Medicare's partial hospitalization benefit.

Recently, HCFA informed twenty CMHCs that the agency intends to terminate their Medicare provider agreements, and sixty more centers are expected to face termination over the next few months, HCFA officials say. In addition, HCFA has

*See **Mental health centers**, page 4*

OIG's 1999 work plan is blueprint for risk assessment

Want to perform effective risk assessment for compliance to federal regulations in your institution without having to spend a fortune hiring a Big Six accounting firm? Then go to OIG's Web site and download the agency's 1999 work plan.

It's all there. You'll find the areas that OIG is focusing on — which means the areas you should be focusing on. "I would use it for my risk assessment," advises **Roy Snell**, a former compliance officer who's now a consultant for Deloitte and Touche in New York. "I would go down the list and find the areas that apply to my institution."

Your best guides to structuring your compliance program are still input from employees and your own compliance audits, Snell adds. "But to ignore the work plan would be foolish."

Many items, such as the hospital upcoding investigations, won't be news to anyone. But there are quite a few new issues that OIG says it will be looking at in 1999. One is end-stage renal disease

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INSIDE:

FLORIDA PODIATRISTS BEAT HCFA IN AUDIT FIGHT 2
INDICTMENTS SERVED ON PSYCHIATRIC HOSPITAL. 4

Hospitals vulnerable

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Beyond false claims suits, cost reporting fraud could have criminal implications. The resemblance between the charges in Alderson's suit and the indictments of Columbia executives last year for falsifying cost reports is no coincidence. Meagher admits that information he obtained working on Alderson's suit was given to federal prosecutors.

In the suit, the government acknowledges that cost reporting basically works on the honor system — a system it claims Columbia exploited. "It is [well] known ... that fiscal intermediaries [FIs] have sufficient resources to perform full audits on fewer than 25% of the cost reports filed each year," it notes.

Columbia officials couldn't be reached for comment. But Quorom CEO **James Dalton** says the company did its best to comply with Medicare rules, and was cooperating with the investigation. More significantly, Dalton says that standard accounting principles require hospitals to maintain reserves against cost reports. "Experience has demonstrated that there are numerous uncertainties and ambiguities, and in the review and auditing process some expenses might not be allowed," according to Dalton.

Alderson's suit alleges that Medicare, Medicaid and CHAMPUS were defrauded because Columbia and the other companies:

- Submitted one set of improper cost reports to the government, but kept a second set that contained correct figures and explicitly identified the expenses that should never have been submitted. The defendants allegedly also maintained special reserves in case the cost reports were denied.
- Labeled some operating expenses as capital expenses to boost Medicare reimbursement.
- Improperly sought reimbursement for interest expenses and used a special depreciation system to fatten reimbursement.
- Charged Medicare for such unallowable costs as physician recruitment expenses, telephone and television services for patients, cafeteria operations, and marketing not related to patient care.
- Fudged statistics used for calculating reimbursement for laundry and housekeeping services and shifted costs from pharmacy and central supply to drugs and medical supplies charged to patients.
- Combined cost centers to boost reimbursement, such as merging day surgery with operating room costs.
- Undercounted interim payments in hopes that it could keep the money until the FIs could calculate the correct amount.
- Switched inpatient costs to the outpatient section of its cost reports.
- Shifted home health and skilled nursing facility costs to hospital-based services. ■

Florida physicians beat HCFA in audit fight

Maybe you can't fight City Hall, but you can fight HCFA when it uses local medical review to extract alleged overpayments. A court challenge by a group of Florida podiatrists has successfully blocked HCFA's attempt to collect $5.5 million.

It's the first time HCFA has agreed to refund money before putting providers through a fair hearing process, says **Gabe Imperato**, the attorney who represented the doctors. The moral of this story is that providers can use the courts to challenge HCFA policies, rather than going through the laborious process of filing appeals before Administrative Law Judges, adds Imperato, JD, at Broad and Cassel in Fort Lauderdale, FL.

The case began in 1997, when BC/BS of Florida audited 170 podiatrists. HCFA disallowed most claims submitted by this group between 1992

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and 1996 for what was essentially treatment of corns and calluses (benign hyperkeriotic lesions — CPT codes 11050-11052).

HCFA had already harvested $2.3 million in refunds from the doctors before the state podiatrists association and its self-insurance pool filed suit. The suit argued that the government had retroactively applied a 1996 local medical review policy. The federal judge slapped an injunction on HCFA's collection effort until the settlement was formally approved by the court last month.

The settlement requires HCFA to refund any money already collected from the doctors, though without interest. It also gives the podiatrists the right to request a hearing before a HCFA Fair Hearing officer. If medical records indicate a lesion was symptomatic (causing pain or other symptoms), HCFA won't count the claim as an overpayment.

Normally the podiatrists would have had to use the bureaucratic appeals process. But because the doctors could show that HCFA tried to apply medical standards retroactively, the government opted for a settlement rather than risking a precedent set by a courtroom defeat, Imperato believes.

But how many providers can afford to go to the mat? The podiatrists filed a class-action suit that cost at least six figures in legal fees alone, Imperato estimates. Fortunately, the podiatrists had created their own self-insurance pool which covered some of the costs of the suit. ■

OIG work plan

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tests. "Our survey disclosed that providers are either separately billing for laboratory tests included in the monthly composite rate or are providing tests that do not conform to professionally recognized standards," says OIG. This could as big and costly an investigation as the lab unbundling probe, says former OIG auditor **John Beattie**.

OIG makes clear that it will more aggressively use its exclusionary powers, which have been beefed up by the Balanced Budget Act. "We anticipate increasing the number of program exclusions" over the next fiscal year, says the OIG. In addition, "We expect to increase the number of patient anti-dumping cases analyzed, negotiated, and litigated, with the resolution of approximately 50 such cases in FY 1999," OIG predicts.

There are a slew of other targets on OIG's investigative agenda. Inquiring government minds want to know more about:

Hospitals

- The relationship between hospital costs and revenues to determine whether Medicare payments are reasonable.
- Whether hospitals are pocketing extra money by submitting claims for patients who are being discharged and then readmitted to the same hospital on the same day.
- Whether hospitals are billing Medicare for experimental drugs that are already funded through other programs.

Physicians

- Whether some doctors charge for excessive visits to nursing homes, including those with a high number of visits on a given day or unusually frequent visits to the same beneficiary.
- If physician billing "errors" are linked to the use of new encoding software. "Results of this work may lead to further reviews," the work plan notes.
- If some podiatry claims lack medical necessity.

Home health

- Whether new rules governing hospital discharges to home health have changed home health utilization.

Nursing homes

- Whether SNFs have been billing for unallowable ancillary supplies.

Durable medical equipment

- Whether DME companies are exploiting the nature of billing codes and the difference in contractor claim processing to submit duplicate claims to DME Regional Carriers and Regional Home Health Intermediaries.

Drug reimbursement

- If nursing home cost reports are being inflated by high prices from infusion therapy suppliers.

Managed care

- Whether Medicare is making duplicate fee-for-service payments to providers who should have been paid by HMOs.
- Whether HMOs are providing appropriate services (OIG will examine what kind of fee-for-service treatments beneficiaries need after they leave HMOs. OIG also will begin surveying fraud and abuse in Medicaid managed care.) ■

Mental health centers

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informed individual states about which CMHCs received notification letters. States will have to decide for themselves whether to terminate Medicaid agreements with these providers or initiate Medicaid-based fraud investigations, says **Ben Jackson**, OIG audit director for field operations for Medicare and Medicaid. Jackson notes that federal investigators are leaving the question of Medicaid fraud enforcement to the states because rules regarding partial hospitalization may differ among states and between Medicare and Medicaid.

Meanwhile, the OIG intends to pursue civil and criminal cases against CMHCs nationwide, says **Ben St. John**, an OIG spokesman. St. John notes that the OIG has already taken action against some CMHCs that provide partial hospitalization services. In at least one instance, the facility was hit with a monetary settlement and the imposition of a corporate integrity program.

HCFA's actions against CMHCs come on the heels of a new OIG report that scrutinized Medicare claims filed by CMHCs in Florida, Texas, Colorado, Pennsylvania, and Alabama. OIG investigators reviewed 250 claims, which accounted for $252 million in payments. They found that 92% of the claims submitted, for a total of $229 million, failed to meet Medicare reimbursement requirements.

HCFA admits that lax enforcement of eligibility requirements for the program helped create the potential for massive fraud. The agency relied "exclusively on the integrity of the applicants" to certify that they met the program's requirements, according to the report.

In a second OIG study, investigators performed on-site reviews of 700 CMHCs in nine states and found that "a large number" of them failed to meet Social Security Act requirements and therefore don't qualify to bill Medicare. (Exact figures aren't available as the study hasn't been completed.)

According to the report, the false Medicare claims from CMHCs fell into five main categories:

1. Beneficiaries were ineligible.

2. Services were not reasonable and necessary, nor were they tailored to individual patients.

3. Services were not authorized, and some medical records lacked physician evaluations and signed plans of care.

4. Documentation was missing, including incomplete assessments and physician notes.

5. Providers were already under investigation, suspended, or terminated from the Medicare program.

In response to the OIG's report, HCFA has released a "10-Point Action Plan" to "curb abuse and protect beneficiaries and taxpayers." Among the points are terminating those CMHCs the agency considers the worst offenders and increasing its scrutiny of new applicants to the partial hospitalization program.

[Note: The report, including HCFA's action plan, is available at the following Web address:

http://www.hhs.gov/progorg/oas/reports/region4/49802145.pdf.] ■

Indictments served in probe of psychiatric hospital

Even as OIG prepares to crack down on fraud at community mental health centers, a special task force has nailed the owners of a Naples, FL. psychiatric hospital with an 89-count indictment. Gary Centafanti, the former administrator of the Willough at Naples psychiatric hospital, and his wife Cathy, the former administrator of the Crisis Response Team in Tampa, were charged with paying kickbacks for referrals as well as money laundering and misapplying hospital funds.

Cathy Centafanti's position in the Crisis Response Team gave her a chance to refer psychiatric patients to her husband's hospital, according to a statement by Charles Wilson, US Attorney for the Middle District of Florida. Wilson claims kickbacks from the hospital were then funneled through another business owned by a friend of the couple. About $953,000 in kickbacks allegedly were made to secure Medicare referrals worth $16.5 million.

Particularly interesting is the dummy management services agreement allegedly devised by the Centafantis. Wilson says the couple used the agreement to convince the hospital's parent company that the business run by their confederate should be paid for providing Crisis Response Team services to the Willough. Ironically, an outside attorney found the agreement fell within the anti-kickback safe harbors established by OIG. ■