

# MEDICAID COMPLIANCE NEWS

Timely News and Practical Strategies for Hospitals, Health Systems and Other Providers

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## Need Grows for Multi-Contractor Tracking System as States, Feds Increase Audits

With many states intensifying Medicaid program integrity reviews, CMS gearing up its Medicaid integrity contractors (MICs), and Medicare auditors breathing down their necks, some health systems are taking a more holistic approach to coping with multiple audit demands. Instead of parceling out medical-records requests to different departments based on the contractor, they are striving for integrated tracking systems that are driven more by content than contractor. The goal is more efficiency in addressing an audit from start to finish — documentation demand through appeal — and it may be the only realistic way to catch the steady stream of audit fly balls lobbed at health systems by Medicaid and Medicare.

“We’re upgrading our Medicaid audit response. I am trying to fold our responses together so we don’t address Medicaid independently of RACs [i.e., recovery audit contractors],” says Becky Cornett, Ph.D., director of fiscal integrity for The Ohio State University Medical Center (OSUMC). “The current Medicaid medical review process isn’t much different than the RACs will be.”

The health systems making this move are mirroring the way the federal government is looking across payer lines in its hunt for payment errors. For instance, “Medi-Medi,” a major CMS program-integrity tool used in at least 10 states, is designed to detect fraud that occurs simultaneously in Medicaid and Medicare. The rationale: “If a provider is doing something bad in Medicare, he’s probably doing something bad in Medicaid,” says Mike Mangano, senior vice president of consulting firm Strategic Management.

*continued on p. 9*

## Supreme Court FCA ‘Presentment’ Decision Boosts Risks for Hospitals, Other Providers

Hospitals and other health care providers are facing increased exposure under the federal False Claims Act (FCA) due to recent court rulings and pending legislation. And one health care attorney has advised providers to prepare for state Medicaid enforcement as well.

The Supreme Court unanimously ruled recently in *Allison Engine Co., Inc. v. United States ex rel. Sanders*, 471 F.3d 610 (6th Cir. 2006), *cert. granted*, 128 S.Ct. 491 (2008) that the federal FCA applies to subcontractors and other indirect recipients of federal funds. Thus, for purposes of liability under the FCA, a plaintiff does not need to show that alleged false claims were actually presented to the government, but it is sufficient that they were presented to a non-governmental intermediary, such as a government contractor, that was ultimately paid with government funds, said the court.

However, the case was remanded back to the Sixth U.S. Circuit Court of Appeals because the court determined that subcontractors must intend that the government rely on the fraudulent claims to get paid in order for there to be liability. The court held that it is necessary for a defendant to intend that a claim be paid by the government

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itself, and not just show that a false statement resulted in the use of government funds to pay a false or fraudulent claim. The plaintiff must show that the defendant intended to defraud the government, the court said.

In an e-mail alert to clients, law firm Sonnenschein Nath & Rosenthal LLP said the Supreme Court's decision will particularly impact health care fraud cases, and it advised the health care industry to monitor "carefully current efforts in Congress to expand the reach of the False Claims Act" through pending legislation.

### Pending Bills Would Expand FCA

Two bills are pending in Congress that would amend and expand the provisions of the FCA, including eliminating the requirements that claims must be presented to an officer or employee of the federal government.

This is referred to as the "Totten" rule or "presentment requirement," and it has allowed contractors to escape civil liability for fraudulent actions if they were not the party that formally presented the claims to the government for payment, according to whistle-blower

law firm Finch McCraine, LLP. The rule makes it easier for defendants to "escape liability for fraudulent conduct on technical grounds," the firm said.

The House Judiciary Committee voted in July to send H.R. 4854, the False Claims Corrections Act of 2007, to the full House for a vote. The related bill, S. 2041, has been placed on the Senate legislative calendar (MCN 8/07, p. 11), although action this year is unlikely.

These proposed amendments would allow liability to be attached "to any request or demand for money or property that is either presented to an officer or employee of the federal government or to a contractor, grantee, or other recipient if the government provides, has provided, or will provide any portion of the money or property requested," according to George Breen, an attorney with law firm Epstein Becker & Green, P.C.

He told attendees at the American Health Lawyers Association's annual meeting in June that with the amendments, "submission of a false claim to recipients of government funds [i.e., hospitals] — even without proof that a claim is later submitted to the government — could trigger FCA liability."

### Circuit Courts Are Split

Breen said that circuit courts were split on whether the FCA requires presentment. The D.C. Circuit Court held in *United States ex rel. Totten v. Bombardier*, 80 F.3d 488 (D.C. Cir. 2004) that claims presented to Amtrak do not meet the presentment requirement because Amtrak is not a government agency (the Totten rule). But the Sixth Circuit in *Allison* found that a subcontractor that submitted false records to a prime contractor is liable under the FCA even without evidence of presentment to the government.

The Third, Eighth and Eleventh Circuits agreed with the D.C. Circuit Court, while the Seventh Circuit agreed with the Sixth Circuit. But now the Supreme Court has resolved the split, finding that claims submitted to subcontractors satisfy the presentment requirement of the FCA.

The decision is already impacting the health care industry. In *United States ex rel. Romano v. New York Presbyterian Hospital*, S.D.N.Y., No. 1:00-cv-08792-LLS, the U.S. District Court for the Southern District of New York refused to dismiss a *qui tam* (i.e., whistle-blower) action brought against a hospital under the FCA for allegedly submitting false bills to the Medicaid program. The court followed the Supreme Court's decision in *Allison* and found that bills submitted to Medicaid payers satisfy the FCA requirement that claims be presented to the federal government.

The court refused to grant the hospital's summary judgment motion because it found disputed factual is-

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sues concerning whether the hospital submitted the bills with the *intent* of having the federal government pay them.

Breen advised the health care industry to pay attention to state Medicaid laws, particularly state false claims acts that have become more popular with the passage of the federal Deficit Reduction Act (DRA).

Under Section 6031 of the DRA, states that enact FCAs modeled after the federal FCA will receive an increased percentage — 10% — of any recovery from a state Medicaid judgment or settlement arising out of the FCA or state law.

According to Breen, state FCAs must establish liability for false or fraudulent claims described in the federal FCA with respect to any expenditure related to state Medicaid plans and must contain provisions at least as effective in rewarding and facilitating *qui tam* actions as those in the federal FCA.

View the Supreme Court's decision in *Allison* at [http://www.sonnenschein.com/practice\\_areas/health-care2/ofInterest\\_detail.aspx?id=45273](http://www.sonnenschein.com/practice_areas/health-care2/ofInterest_detail.aspx?id=45273). Contact Breen at [GBreen@bglaw.com](mailto:GBreen@bglaw.com). ✧

## Texas Clinics Bill for Dead Patients; Owner Gets 15 Years in Prison

A Texas man who owned two occupational and physical therapy clinics was sentenced last month to 15 years in prison for allegedly billing federal health care programs for services that were never provided — some for patients who had died, according to the Texas Attorney General's office.

Albert C. Albert, owner of Skillcare Rehabilitation Services and Nelbat Rehabilitation Services, billed for services that were never provided between February 1999 and February 2004, the state says. He received more than \$170,000 from the federal health care programs for the services, and \$55,000 of that total was for services that were dated after the deaths of 34 patients.

Texas's Medicaid Fraud Control Unit began investigating Albert based on a letter from the state nurse licensing board, says Thomas Kelley, spokesman for the attorney general's office. "A home health agency received a complaint from one of their clients, after the client received an explanation of benefits letter, that [Albert] was billing Medicare Part B for services that were not rendered," he explains.

Investigators interviewed 33 patients and discovered that most of them had never received the treatments that the clinics reported in billings to the government, according to the state.

Albert was indicted in October 2007 and was charged with first-degree felony theft by a governmental contractor. The Harris County District Attorney's office was preparing for court when Albert waived his right to a jury trial in May and pleaded guilty, Kelley tells *MCN*. Albert was not offered a plea agreement and was not ordered to pay restitution, he adds. Kelley says the presentence investigation report, which could explain the sentence given to Albert, is not a public document.

An attorney for Albert could not be reached for comment.

Federal and state officials have made it clear that they know there are many providers out there just abusing the system, and "this type of case highlights that there *are* people abusing the system," says Cynthia Stamer, who is in the Dallas office of law firm Glast Phillips and Murray.

### Not Your Average 'Oops We Goofed' Conduct

Noting that Albert billed for dead patients and for services other patients said they never received, Stamer says Albert likely received a stiff sentence because the conduct was "not your average 'oops, we goofed' conduct.... It was conscious," Stamer added, "This is fraud that the public understands, not the artificial definition that comes from coding claims and having differing opinions."

According to Stamer, the prosecution also is notable because it was brought by the state of Texas, rather than the Justice Department. Even though official pleadings and the announcement of the plea agreement alleged that Albert falsely billed Medicare as well as Medicaid, federal prosecutors were not responsible for the prosecution that led to Albert's conviction.

Stamer points out that state officials had jurisdiction over the Medicaid claims, but that the Medicare fraud action generally would fall under federal jurisdiction. Stamer says that it is not clear what involvement, if any, that federal prosecutors might have had, or be contemplating in response to any false claims made to Medicare or another federal health plan, if any. Theoretically, charges are still possible for the Medicare and any other false federal health plan claims, and the HHS Office of Inspector General (OIG) has targeted this area before, she points out.

In a December 2007 OIG audit report, one Texas physical therapy company owner was told to refund more than \$280,000 to Medicare. OIG audited 100 claims from 2002 and found that 97 of them did not meet Medicare's requirements (three claims were discounted because the payments had already been recovered). In that case, the owner allegedly also inappropriately used his Personal Identification Number (PIN) to bill for services

that had been supervised by someone else. The owner disagreed with the findings.

So with federal and state officials and all their intermediaries looking for fraud, "people who bend the rules are going to get caught," says Stamer.

Contact Stamer at (972) 419-7188. Visit [www.oag.state.tx.us](http://www.oag.state.tx.us). ♦

## **Florida MFCU Is Accused of Continuing Pattern of Misconduct**

The latest audit of the Florida Medicaid Fraud Control Unit (MFCU) by the Florida Auditor General indicates that 1,270 cases were closed by the state MFCU from July 2005 through February 2007. But that might not show the complete picture, according to the founder of a Florida-based health care firm.

In 2003, the HHS Office of Inspector General (OIG) sent a letter to the Florida MFCU, citing the MFCU for not providing complete and accurate case information, employing individuals who did not meet established minimum qualifications, and other deficiencies. OIG called the state a "high risk" grantee, at risk of losing millions of dollars in federal funding from Medicaid, and it placed the MFCU on probation for a year. Within that

time frame, the MFCU was required to meet recertification criteria and conform to grant requirements.

In 2004, after the MFCU refunded approximately \$186,000 that was used in the investigation of recipient fraud, OIG removed the "high risk" status. Then, the Florida Auditor General conducted a follow-up audit in September 2005 (2004-033) to determine whether appropriate corrective actions had been taken based on OIG's report.

Of the 316 cases completed by the MFCU during the period February 2004 through January 2005, the report found that 21% resulted in convictions or settlements, with total restitution of approximately \$54.8 million. The audit specifically found the following deficiencies, some of which were also found in the 2003 report:

- (1) The MFCU data systems did not provide complete and accurate case information.
- (2) The MFCU continued recipient fraud investigations for 18 of 129 cases identified in the previous audit report and not authorized for federal financial participation.
- (3) Some efforts by the MFCU to identify potential fraud included activities and costs that were not allowable under federal regulations.

## ***New DOJ Guidelines Protect Attorney-Client Privilege in Health Care Fraud Suits***

The Department of Justice (DOJ) late last month issued revised guidelines for prosecuting corporate fraud, including health care fraud investigations. The new guidelines allow health care organizations to self-disclose potential misconduct to DOJ without having to waive attorney-client privilege and potentially expose underlying communications with counsel.

Under the "Principles of Federal Prosecution of Business Organizations," announced by Deputy Attorney General Mark Filip on Aug. 28, corporations do not need to waive attorney-client privilege or work-product protections to receive credit for cooperating with OIG. The revised guidelines make clear that the receipt of credit for cooperation depends on full disclosure of the relevant facts. In addition, the guidelines instruct prosecutors not to consider a corporation's advancement of attorneys' fees to its employees under investigation when evaluating cooperativeness. The guidelines also make clear that mere participation in a joint defense agreement between the company and an

employee will not render a corporation ineligible for cooperation credit.

The guidelines govern how federal prosecutors investigate, charge and prosecute corporate crimes. The new guidelines state that "corporations that disclose relevant facts may receive due credit for cooperation, regardless of whether they waive attorney-client privilege or work product protection in the process."

The new guidelines also provide for other changes. For example, once organizations are under investigation, prosecutors should not ask for privileged materials. Prosecutors also should not hold it against organizations if they furnish employees with legal counsel.

DOJ says the revisions and policy changes will be committed to the United States Attorneys' Manual, which is binding on all federal prosecutors within the department. The revised principles will be effective immediately.

Visit [www.usdoj.gov/opa/pr/2008/August/08-odag-757.html](http://www.usdoj.gov/opa/pr/2008/August/08-odag-757.html).

(4) The MFCU did not always appropriately and in a timely manner distribute restitution received to compensate the Medicaid program.

(5) The MFCU distributed \$5.4 million to the state Agency for Health Care Administration that should have been made available to the legislature for appropriation.

(6) The MFCU did not always transfer checks received to the department's finance and accounting office in a timely manner and did not establish procedures for collecting restitution amounts.

(7) The MFCU did not ensure a proper skills mix among its staff, and it employed individuals who did not meet established minimum qualifications.

(8) The MFCU motor vehicle fleet was not utilized effectively and efficiently.

(9) The MFCU did not ensure that evidence-room inventories were properly conducted or documented.

In response to the audit findings, the Florida Office of the Attorney General, under which the MFCU falls, said it had taken action based on OIG's 2003 report to "create and modify policies and procedures; enhance our case tracking and time management systems; propose new legislation combating Medicaid fraud; and increase staffing and resources to combat Medicaid fraud." It specifically pointed to the fact that its "high risk" status had been removed in 2004 as proof of its corrective actions.

### State Fixed Most Deficiencies

In another follow-up audit in August 2007 (2006-028), the Auditor General focused on the status of the findings in the 2005 audit. The 2007 audit "indicated that Department management implemented sufficient corrective action to resolve the prior audit findings," with two exceptions: The MFCU case files did not always include documentation of the calculation of Medicaid overpayments, and the amounts due to the Medicaid program were not always remitted in a timely manner.

From July 2005 through February 2007, 1,270 arrests were made, with the cases closed by the MFCU, said the report. Of those 1,270 cases, 88 resulted in convictions or settlements, and 1,182 cases were found to lack evidence or were unfounded.

The audit recommended that the MFCU should take steps to better ensure staff compliance with established procedures, such as enhanced supervisory monitoring of procedural compliance, and it should coordinate efforts with the finance and accounting department to ensure restitution is remitted in a timely manner.

The attorney general's office again responded that since the previous audit it had instituted procedures and controls to improve the accuracy and completeness of

documentation contained in the case-tracking database and associated case files.

It also stated that it was reviewing procedures regarding the submission of restitution and claimed that the two "untimely transfers resulted from errors that were detected by current internal controls and were self-corrected prior to the audit."

Sandra Frank expressed concerns with the 1,182 cases that were listed as lacking evidence or were unfounded. In a commentary in the Aug. 17 *North Country Gazette*, a New York Adirondack mountain area newspaper, Frank, a registered dietitian and licensed nutritionist who founded Weighing Successes, said that if the 1,182 wrongly accused people were included in the 1,270 arrests, it skews the results. She accuses the Florida attorney general's office of creating a "witch hunt" just to arrest a few so it would appear like the state "was taking aggressive actions to correct problems with the MFCU."

Frank also says an MFCU that has been cited four years for not verifying information or not always providing documentation shows a "pattern of misconduct."

The attorney general's office did not respond to a request for comments before *MCN* press time.

To view the complete audit reports, visit [www.myflorida.com/audgen/pages/releasedreports.htm](http://www.myflorida.com/audgen/pages/releasedreports.htm) and click on "State Agencies." ✧

### Compliance Resources From AIS

✓ *Report on Medicare Compliance*, the industry's leading compliance newsletter, with weekly news and insightful analysis of the key compliance problems that lie ahead for the industry.

✓ *Medicare Part D Compliance News*, monthly news and strategies on marketing, enrollment, formularies, rebates, claims pricing, and fraud, waste and abuse.

✓ *Report on Research Compliance*, a monthly newsletter, weekly e-letters and subscriber-only Web site on conflict of interest, human subjects, scientific misconduct, tech transfer and much more; copublished by NCURA.

✓ *A Guide to Complying With Stark Physician Self-Referral Rules*, a comprehensive looseleaf (plus quarterly updates) with practical summaries of the federal rules and separate analyses for hospitals, physician groups and other stakeholders.

**Visit the AIS MarketPlace at  
[www.AISHealth.com](http://www.AISHealth.com)**

**Match Rates of Final Action Data and the Exclusions Database by State**

State	No. of providers that matched the exclusions database	Percentage of providers that matched the exclusions database	No. of providers that did not match the exclusions database	Percentage of providers that did not match the exclusions database	No. of providers for which OIG could not determine a match	Percentage of providers for which OIG could not determine a match	Total number of providers with final actions collected for evaluation
Ala.	161	93.6%	11	6.4%	0	0.0%	172
Alaska	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
Ariz.	The state Medicaid agency reported that it does not take final actions against providers and did not complete the survey or data request.						
Ark.	0	0.0%	2	100.0%	0	0.0%	2
Calif.	The state Medicaid agency submitted incomplete data that OIG was unable to use in its analysis.						
Colo.	10	33.3%	20	66.7%	0	0.0%	30
Conn.	4	30.8%	8	61.5%	1	7.7%	13
Del.	1	50.0%	1	50.0%	0	0.0%	2
D.C.	2	10.5%	16	84.2%	1	5.3%	19
Fla.	75	8.7%	786	91.0%	3	0.4%	864
Ga.	14	51.9%	13	48.1%	0	0.0%	27
Hawaii	The state Medicaid agency did not respond to the survey or the data request.						
Idaho	16	84.2%	3	15.8%	0	0.0%	19
Ill.	24	47.1%	26	51.0%	1	2.0%	51
Ind.	10	40.0%	15	60.0%	0	0.0%	25
Iowa	11	26.2%	29	69.1%	2	4.8%	42
Kan.	4	33.3%	8	66.7%	0	0.0%	12
Ky.	45	56.3%	35	43.8%	0	0.0%	80
La.	138	85.2%	23	14.2%	1	0.6%	162
Maine	59	79.7%	14	18.9%	1	1.4%	74
Md.	74	54.8%	61	45.2%	0	0.0%	135
Mass.	0	0.0%	2	100.0%	0	0.0%	2
Mich.	The state Medicaid agency submitted incomplete data that OIG was unable to use in its analysis.						
Minn.	9	25.7%	26	74.3%	0	0.0%	35
Miss.	4	100.0%	0	0.0%	0	0.0%	4
Mo.	54	62.8%	31	36.1%	1	1.2%	86
Mont.	5	62.5%	3	37.5%	0	0.0%	8
Neb.	1	12.5%	7	87.5%	0	0.0%	8
Nev.	1	16.7%	5	83.3%	0	0.0%	6
N.H.	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
N.J.	32	68.1%	14	29.8%	1	2.1%	47
N.M.	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
N.Y.	280	20.8%	1,061	78.7%	7	0.5%	1,348
N.C.	20	12.1%	146	88.0%	0	0.0%	166
N.D.	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
Ohio	73	41.0%	103	57.9%	2	1.1%	178
Okla.	0	0.0%	16	100.0%	0	0.0%	16
Ore.	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
Pa.	29	90.6%	3	9.4%	0	0.0%	32
R.I.	0	0.0%	1	100.0%	0	0.0%	1
S.C.	36	94.7%	2	5.3%	0	0.0%	38
S.D.	The state Medicaid agency reported that it does not take final actions against providers and did not complete the survey or data request.						
Tenn.	The state Medicaid agency submitted incomplete data that OIG was unable to use in its analysis.						
Texas	438	81.0%	94	17.4%	9	1.7%	541
Utah	5	83.3%	1	16.7%	0	0.0%	6
Vt.	The state Medicaid agency reported taking no final action against providers in 2004 and 2005. The agency did complete the survey.						
Va.	9	39.1%	12	52.2%	2	8.7%	23
Wash.	12	66.7%	6	33.3%	0	0.0%	18
W.Va.	The state Medicaid agency did not respond to the survey or the data request.						
Wis.	11	44.0%	13	52.0%	1	4.0%	25
Wyo.	0	0.0%	2	100.0%	0	0.0%	2
<b>Total</b>	<b>1,667</b>	<b>38.6%</b>	<b>2,619</b>	<b>60.6%</b>	<b>33</b>	<b>0.8%</b>	<b>4,319</b>

SOURCE: OIG, Memorandum Report: State Medicaid Agency Referrals to the Office of Inspector General Exclusions Program for 2004 and 2005, Aug. 5, 2008

## State Agencies Often Don't Submit Final Actions on Providers to OIG

A majority of providers with final actions imposed by state Medicaid agencies in 2004 and 2005 are not listed in the HHS Office of Inspector General exclusions database, and these agencies reported confusion surrounding the referral process, according to a recent survey by OIG.

OIG reviewed matched data from the exclusions database that contains information on providers with final actions taken by state Medicaid agencies in 2004 and 2005 and also surveyed state Medicaid agency officials from November 2006 through April 2007. States were asked to submit information on all providers with final actions taken between Jan. 1, 2004, and Dec. 31, 2005. Information requested included providers' names, addresses, tax identification numbers, types of profession/business, dates of birth, types of actions taken against providers, and dates of actions. This information was then matched against the data from the exclusions database.

Pursuant to Section 1902(a)(41) of the Social Security Act, state Medicaid agencies must notify OIG whenever state or local courts convict providers of offenses related to participation in the Medicaid program. This requirement is waived if the state Medicaid Fraud Control Unit has already reported the conviction to OIG.

OIG found that state Medicaid agencies reported taking 4,319 final actions against providers in 2004 and 2005, but almost 61% of these final actions were not found in the exclusions database (see table, p. 6). Approximately 39% of providers' final actions were found in the exclusions database, and matches could not be determined for 0.8%.

Match rates varied across states, the survey showed, with 11 states having match rates of less than 25%, and nine states having match rates greater than 75%. Approximately half of the states with low match rates took few final actions against providers, said OIG. Six of the

11 states with match rates of 25% or less took final actions against fewer than 10 providers. Four of those six states took action against two or fewer providers.

OIG said that state Medicaid agency officials "conveyed uncertainty about the types of information to send with referrals, the types of final actions to refer to OIG and the outcome of the referrals that they make." And officials from 22 out of 47 agencies cited "unclear guidance and instructions from OIG" regarding documentation to send with referrals. One state Medicaid official said, "If a referral is made, we don't know the documentation requirements."

Moreover, 19 out of 47 state Medicaid agencies cited uncertainty about the final actions that need to be referred to OIG, with six officials commenting that they were "unaware that they were supposed to report final actions to OIG." "The agency has not referred actions to OIG as we did not believe our process met OIG's definition of a termination," said one state official.

However, despite such conveyed uncertainty, OIG said that agencies have rated recent outreach from OIG as "helpful" and said they would like more information about the exclusions processes. And "several" agencies that received outreach "commented positively on their working relationship with OIG," the report said.

OIG determined that "opportunities exist for both OIG and state Medicaid agencies to increase the number of referrals of providers with final actions," and suggested increasing outreach to improve the two entities' working relationship. However, the report, provided to David Frank, director of the Medicaid Integrity Program at CMS, did not contain any recommendations.

A CMS spokesperson tells *MCN* that since the report did not make any recommendations for action on the part of the agency, "it is likely we would not have any comment."

Visit <http://oig.hhs.gov/oei/reports/oei-01-06-00301.pdf>. ✧

### NEWS BRIEFS

◆ **CMS and the Indian Health Service have worked together to provide support to IHS-funded facilities and tribes in accessing Medicaid and Medicare and to address broader policy and regulatory concerns regarding state Medicaid programs with mixed success**, according to a recent report of the Government Accountability Office (GAO-08-724). Out of six state Medicaid programs reviewed by GAO, five of the six states reported having policies in place that governed the interactions between the

state's Medicaid program and Indian tribes, with most of these policies establishing guidelines for how consultation should be conducted. And five states reported consulting with tribes about changes to their Medicaid programs. However, GAO acknowledged that "consulting with tribes is an inherently difficult task" and that regional sessions have "offered limited time for consultation and discussion." CMS commented that it was appreciative of GAO's review of CMS activities related to interactions with

**NEWS BRIEFS (continued)**

IHS and tribes. Go to [www.gao.gov/highlights/d08724high.pdf](http://www.gao.gov/highlights/d08724high.pdf).

◆ **Almost all major health care fraud cases prosecuted since the early 1990s were initiated by whistle-blowers and have resulted in approximately \$9.3 billion in recoveries**, according to an article in the Sept. 2 issue of the *Annals of Internal Medicine*. The authors looked at 379 unsealed cases that were resolved between 1995 and 2006. The whistle-blowers received a total of approximately \$1 billion from their involvement in the cases, the article says. Visit [www.annals.org](http://www.annals.org).

◆ **The HHS Office of Inspector General (OIG) determined in a recent audit report that the Agency of Human Services, Office of Vermont Health Access did not implement recommendations from a previous audit of the state's Medicaid drug rebate program (A-01-08-00004)**. The report also found that the state did not have adequate policies and procedures for reconciling and reporting its pending drug rebate amounts on Form CMS 64.9R to ensure the accuracy of pending drug rebate amounts, but the state had established controls over collecting rebates on single-source drugs administered by physicians. OIG reiterated its recommendation that the state implement policies and procedures for properly monitoring and collecting interest owed by manufacturers for late, disputed and unpaid drug rebate amounts and that it develop a pending drug rebate aging schedule for use in properly preparing the CMS 64.9R report. OIG also recommended that the state improve its policies and procedures for reconciling the receivable balance on CMS 64.9R to the amount reported on the accounts receivable system to ensure accuracy of pending drug rebate amounts reported to CMS. The state agreed with OIG's findings and recommendations. Go to [www.oig.hhs.gov/oas/reports/region1/10800004.htm](http://www.oig.hhs.gov/oas/reports/region1/10800004.htm).

◆ **The Maine Department of Health and Human Services made overpayments of approximately \$618,000 because it did not adjust its Medicaid per-diem payments to North Country Associates, Inc. by the amount of the beneficiaries' cost-of-care contribution from other resources, such as Social Security and pensions**, OIG said (A-01-07-00012). The audit report found that the adjustment was not made because the state agency's new computer system could not reduce payments to nursing

homes by beneficiaries' cost-of-care contributions as appropriate and refund any collected overpayments. OIG recommended that the state collect the overpayments and refund the federal share to CMS on its next quarterly Form CMS-64, and that it continue its efforts to ensure that Medicaid payments to nursing homes are identified, collected and refunded. The state agreed with OIG's findings. Visit [www.oig.hhs.gov/oas/reports/region1/10700012.pdf](http://www.oig.hhs.gov/oas/reports/region1/10700012.pdf).

◆ **New Jersey improperly received federal Medicaid reimbursement for family planning claims, according to a recent OIG audit report (A-02-06-01020)**. The report determined that the state improperly received Medicaid reimbursement for 111 of 161 claims in a statistical sample. For these claims, the state received payment at the enhanced 90% rate. OIG found that the overpayment occurred because the state's Medicaid Management Information System (MMIS) did not have edits or controls to identify all claims for which family planning service was performed with non-family planning procedures during a single inpatient hospital stay, and some hospitals did not properly complete sterilization consent forms. OIG recommended that the state refund the improperly received amounts to the federal government; develop edits and controls to its MMIS to identify all improper claims; reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and submitted for all Medicaid sterilizations; and determine the amount of funds improperly reimbursed at the 90% rate for inpatient hospital services subsequent to the audit period and refund that amount. The state generally agreed with OIG's recommendations. Go to [www.oig.hhs.gov/oas/reports/region2/20601020.pdf](http://www.oig.hhs.gov/oas/reports/region2/20601020.pdf).

◆ **OIG issued a follow-up audit (A-04-07-07024) of Alabama's Medicaid drug rebate program, finding that the state had implemented recommendations from the previous audit related to the collection of interest and the utilization of write-off criteria for dispute resolution**. The follow-up audit also found that the state agency established controls over collecting rebates on single-source drugs administered by physicians. OIG did not make any additional recommendations. Visit [www.oig.hhs.gov/oas/reports/region4/40707024.htm](http://www.oig.hhs.gov/oas/reports/region4/40707024.htm).

## Feds, States Intensify Audits

*continued from p. 1*

So far, Medi-Medi is bearing fruit. CMS says it saves \$5.50 for every \$1 spent on Medi-Medi, according to Jeff Richards, project manager of the Western Integrity Center, which is part of the Comprehensive Error Rate Testing (CERT) program contractor AdvanceMed. That's just one reason the program will be expanded. Congress, in the Deficit Reduction Act, gave CMS the money to take Medi-Medi nationwide. Funding is \$12 million an-

nually now, but will rise to \$60 million a year by 2010, Richards says.

Similarly, CMS is developing "One PI," a vast program-integrity computer system, Mangano says. "Eventually it will have all Medicaid and Medicare data. That will make it easy for the OIG [i.e., the HHS Office of Inspector General] and CMS and [Government Accountability Office] to look at data across programs" to find provider errors, says Mangano, a former deputy IG.

In other words, the days of siloing — a well-known enemy of compliance and enforcement — are over.

*continued*

### *States Ramp Up Audits; Some Program Integrity Outsourced*

At least two states, Iowa and Indiana, outsource the bulk of their Medicaid program-integrity operations. For example, in Iowa, Medicaid outsources most of its Medicaid program-integrity work, but things have gotten a lot hotter for providers since 2005, when the state changed its contracting approach, says Patty Ernst-Becker, program-integrity manager for Iowa Medicaid Enterprise, the Medicaid agency. "There is more Medicaid scrutiny," she notes.

Before July 2005, Iowa used a "fiscal agent," which is akin to a Medicare contractor. The fiscal agent performed all program-integrity work except prepayment reviews, which were handled by Iowa's quality improvement organization (QIO). But the return on investment was inadequate, so Iowa decided to break up the contracts, Ernst-Becker says. Providers have taken notice.

For one thing, post-payment reviews are now done by a contractor overseen by the Medicaid agency's surveillance and utilization review system (SURS) unit. The contract stipulates that the money collected through audits or cost avoidance must equal 350% of the state cost of the contract. "Based on that contractual requirement, our SURS work has easily quadrupled," Ernst-Becker says. Now 13 people work full-time on post-payment reviews, compared with the fiscal agent's 1.5 full-time equivalents. "It's making an impact on providers who had never had a Medicaid audit before," she says.

Different contractors do other parts of Iowa's program-integrity work. For example, a QIO continues to do prepayment reviews; it also manages the Medicaid agency's recipient lock-in program. Ernst-Becker says all states have lock-in programs for Medicaid enrollees who overuse services. They are permitted to use only certain providers and suppliers (e.g., pharmacies). If

these enrollees try to use different providers or suppliers, the QIO notifies them of the enrollee's restricted status and directs them not to treat/serve the enrollee.

Only five Iowa program-integrity staffers are employed by the state. They consist of Ernst-Becker, a soon-to-be hired assistant and three Division of Fiscal Management employees who do Medicaid audits of school-based services and home community-based waiver providers.

In Wisconsin, the Medicaid Bureau of Program Integrity, which morphed from a SURS, has expanded to 95 employees — an increase of 20 people in the past couple of years, says Alan White, director of program integrity in the Department of Health Services, the state Medicaid agency. All 20 new employees do audit-related work. He says most state Medicaid auditors "have now taken care of the low-hanging fruit" — such as billing for services after the recipient dies — and are "looking for ways to find subtler errors." Algorithms and other data-mining tools help identify services that don't match diagnoses or services that don't jibe with other services (e.g., a patient who has a lot of physician charges but lacks expected pharmacy charges, or a patient who travels far outside his service area to fill a prescription).

White says Wisconsin's program integrity group uses both its own data analysts and outside contractors to find billing vulnerabilities. For example, "we have a contractor to look at credit balances where a provider owes Medicaid because [the claim] was paid by another source," he says. "It supplements what we have in house." Also the program integrity group has non-nurse auditors who look at areas that don't require medical judgment, such as cost reports.

Contact Ernst-Becker at [pernstb@dhs.state.ia.us](mailto:pernstb@dhs.state.ia.us) and White at [whiteas@dhfs.state.wi.us](mailto:whiteas@dhfs.state.wi.us).

On the state level, many Medicaid agencies have stepped up their provider audits. In some states, surveillance and utilization review systems (SURS) have been absorbed into more active program integrity departments (which are distinct from Medicaid fraud control units). Providers now face either Medicaid inspectors general (e.g., in New York, Texas, Florida and Tennessee) or Medicaid program-integrity departments. Their approaches to identifying overpayments and fraud often vary from state to state (see story, p. 9).

### **Medical Necessity Is Focus in Ohio**

It seems clear to officials of OSUMC that Medicaid scrutiny is intensifying. Reviews by Permedion, a quality improvement organization (QIO) with an Ohio Medicaid contract to audit providers in certain areas, "have been stepped up," says Cornett.

OSUMC is facing all kinds of Permedion reviews — including DRG coding and billing — but the emphasis is on the medical necessity of hospital admissions, says Carol Osborn, associate director for coding and compliance at OSUMC.

"Medical-necessity denials are an easy target," Osborn says. Some patients are discharged and readmitted within a very short time frame, she says. "We have a lot of patients who are chronically ill." Until there is a better solution for outpatient management of chronic conditions, denials will persist because acute-care hospitals are not designed or reimbursed for chronic care, Osborn says. Earlier in September, Permedion issued two medical-necessity denials for a Medicaid patient's August admission and September readmission. Permedion maintains the patient should have been treated on an outpatient basis. "It's difficult to avoid some readmissions because outpatient programs may not meet certain patients' needs. We treat them and then are told it was medically unnecessary to admit them [as inpatients]."

Permedion also has been doing entire bill audits — line-by-line scrutiny. That means they require the hospital to provide documentation for every single charge on the bill, including proof the physician ordered the drugs or services and proof the drugs were truly administered and/or the services were provided. "Within the past couple months, they are asking for more of these for Medicaid patients," she says.

Though most Permedion Medicaid reviews are medical-necessity related, Osborn says OSUMC has its share of DRG coding and billing audits. For example, in terms of DRGs, Permedion recently challenged the DRG sequencing of a pregnant trauma patient. Osborn agreed that the hospital made an error when the trauma was coded as the principal diagnosis; the pregnancy should have been the principal diagnosis. In terms of billing is-

sues, Permedion also hits hospitals when they bill incoming Medicaid transfers as regular admissions. If a patient is transferred to a hospital, the receiving hospital should split the DRG payment with the transferring hospital.

"Medicaid auditors are here all the time — it's an increased presence," Osborn says. But often OSUMC successfully defends its claims to Medicaid auditors, she says.

California and New York are two very active states. Jim Sheehan, New York's Medicaid IG, is making history in the Medicaid program-integrity world. New York state now has the nation's largest Medicaid data warehouse, which is used to identify patterns of suspicious provider, supplier and recipient behavior that often could be invisible under conventional audit and investigation methods. Sheehan doesn't keep the state's Medicaid audit and investigation plans secrets from providers. Last April, New York became the first state to publish a Medicaid work plan, which is a blueprint for Sheehan's Medicaid Integrity Group's program-integrity activities. These developments are just a taste of what's in store for New York from the former federal prosecutor.

California has added 422 staff to its Medicaid anti-fraud program since 1999, according to the Medicaid Audits and Investigations department, which is inside the state Medi-Cal (Medicaid) agency. Also big on data mining and data analysis, the Audits and Investigations department uses a data analysis program, the Fair-Isaac Program, to identify fraudulent activities. "The Fair-Isaac Program is used by credit card companies to detect fraudulent patterns; the program is also helpful in identifying health care fraud," a spokeswoman says. "Data mining tools have been successful in identifying emerging patterns of fraud, waste and abuse. [The Audit and Investigations department] employs a number of algorithms that often are indicators of fraud and abuse."

### **'Defense Audit Process' Is One-Stop Shop**

WellSpan Health in York, Pa., has moved aggressively to streamline the process of tracking all government audits. Compliance Officer Wendy Trout says WellSpan is developing a "defense audit process" — a central process for managing activity involving state Medicaid audits, MIC audits (when they begin), RACs, the CERT contractor, Payment Error Rate Measurement (PERM), and additional documentation requests (ADRs) from the Medicare fiscal intermediary.

"Things will be looked at by content, not by contractor," Trout says.

The heart of the defense audit process will be a database. All payer audit requests will be logged into the database. The goal: "so we can see what is going on systemwide regardless of who requested the medical

record," she says. The database will be a central repository for the history of the audit — the request for medical records (or onsite audit), the filing of an appeal when relevant and the outcome. The process will be managed by a "defense audit coordinator," a WellSpan employee who was reassigned part-time from another job.

With all the information in the database, WellSpan should be able to identify patterns of an error earlier and fix it before other program-integrity hunters and gatherers zero in on that particular error. That's preferable to the way it's siloed now. For example, compliance handles Medicaid DRG review requests, revenue management does Medicare ADRs, care management is responsible for Medicaid medical-necessity reviews, etc. Each department has its own spreadsheet for containing medical records and tracking results.

"We want to get our arms around one central process," Trout explains. "We will get more efficient because the same people will be handling it internally." When the government audit focus is on coding, WellSpan coders will review the case. Same goes for nurses when the audit is clinical, and case managers when medical necessity is the target.

The people assigned to the defense audit process "will have a portion of their jobs dedicated to gathering the medical record and reviewing it for appropriateness before it goes out the door," she says. So when WellSpan has an indication there are errors with, for example, cardiac care, it will be able to retrieve that information for all payers. "The data can be pulled out in different ways," she says.

### Steps in Defense Audit Process

Here are the tentative steps of the defense audit process, which Trout says is still a work in progress:

**(1) Record request is received for external review.**

Requests could come through a state Medicaid program-integrity review (e.g., DRG coding/medical necessity and Medicaid charge audits for services like neonatal intensive care unit babies); RACs; CERT; Medicare ADRs from the fiscal intermediary, which are typically focused on particular areas, like dialysis or sleep labs.

**(2) Defense audit process's administrative assistant logs the request in the database** to ensure all deadlines for documentation are met. (Database already includes all RAC deadlines. WellSpan's vendor says it will add timelines for other common record requests, such as Medicaid.)

**(3) Medical records are gathered by the medical records department.** This includes electronic records and paper and microfilmed records, which are scanned in. These records are available for viewing at the desktop computer in the release-of-information system.

**(4) Additional records are gathered by the defense audit process staff.** This could include billing information, care management documentation, requisitions and physician office documentation when necessary to support orders when there is no signature on order requisitions or there are other local coverage decision requirements.

**(5) If the reason for review is known (e.g., it's supposed to be noted on RAC requests), the record is reviewed by either the nurse auditor** (if reason for the review is clinical, such as medical necessity), the senior auditor (if it's a non-clinical billing issue), or the coder (if it's a coding issue).

**(6) A fact sheet is prepared to accompany the record submission.** It highlights important information in the record so the external reviewer can easily identify support for the services billed.

**(7) Ensure that all records in three, four and six are scanned into the release-of-information system** and that the records are released. The release-of-information system sends the records out and tracks the submission.

**(8) Results and appeal information are logged as they return.** All supporting documentation is scanned into the database and tied to the patient record reviewed.

**(9) The defense audit coordinator will regularly monitor the database,** hunting for patterns of errors that need corrections, opportunities for education, and issues with the submission of records or submission of appeals that need addressing.

OSUMC is another health system that is trying to reverse the "compartmentalization" of audits that has occurred over time, Cornett says. The academic medical center is planning a process for consolidating the tracking of all Medicaid, Medicare and private-payer audits. The tracking will start with the receipt of the request for medical records (from any contractor) and follow through the last appeal decision, says Cornett, with a core group of people making decisions about appeals (bringing in different expertise depending on the nature of the appeal). "Otherwise you've got piles of paper and no way to know what happened" to the audits, "with millions of dollars at stake," she says.

Part of the driving force for the all-contractor tracking process was the realization that people were treating RACs like some big anomaly. "It's not that different," according to Cornett, except perhaps for the magnitude. The same goes for the MICs. Health care organizations have always coped with audits — there are just more contractors now. "People should look at improving their current processes and add RACs and MICs and have more integrated approaches," she says.

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**STATE MEDICAID COMPLIANCE NEWS**

◆ **The California Department of Health Care Services (DHCS) has two weeks as of Aug. 28 to comply with an Aug. 18 preliminary injunction against a 10% cut in Medi-Cal rates**, said U.S. District Court Judge Christina Snyder. In response to an emergency appeal in *Independent Living Center of Southern California, et. al. v. Shewry* (No. CV 08-3315 CAS), the Ninth Circuit Court of Appeals ordered a halt to the 10% payment cuts for prescription drugs dispensed under the Medi-Cal program until at least Aug. 11 and sent the case back to federal district court for further consideration of the plaintiff's motion for a preliminary injunction. But at an Aug. 28 hearing, Snyder determined that DHCS had two weeks to comply with the Ninth Circuit's decision before she held it in contempt of court. The Medicaid cuts originally went into effect July 1, and the injunction applies only to Medi-Cal services provided after the Aug. 18 order.

◆ **The Michigan Department of Community Health suspended the license of Detroit-based dentist Lawrence Stewart**, MDCH said Aug. 29. Stewart was convicted June 6 of 41 counts of filing fraudulent Medicaid claims, sentenced to one year in prison and 60 months probation and required to pay approximately \$131,089 in court costs, fines and restitution. According to MDCH, Stewart failed to report the conviction to the department. On Aug. 18 MDCH issued an order immediately suspending Stewart's license. The Public Health Code provides for mandatory summary suspension of a health professional upon conviction for a felony, a misdemeanor punishable by imprisonment for up to two years or a controlled substance-related conviction. Go to [www.michigan.gov/mdch/0,1607,7-132-27417--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417--,00.html).

◆ **Oneida County (New York) Judge Michael Dwyer has recused himself from a Medicaid fraud case involving the director of Utica, N.Y.-based Center for Addiction Recovery (CAR)**. According to the motion by defense attorney Frank Policelli, Dwyer's law clerk, Carl Del Buono, was chairman of the board of directors of Insight House Chemical Dependency Services at approximately the same time Ole Petterson is accused of fraudulently receiving approximately \$500,000 from the state Medicaid agency through false billing. Policelli said that CAR was awarded a contract instead of Insight House in 2003. This led to acrimonious letters being exchanged between the two companies, he said. Policelli cited the "appearance of partiality" in asking that Dwyer

step down. Now, the case has been assigned to Judge Barry Donalty, and a trial date has been set for Oct. 6.

◆ **The owner and director of the Newark, N.J.-based Samaritan Medical clinic pleaded guilty to second-degree health care fraud**, according to state Attorney General Anne Milgram. Milgram's office alleged that Bryan Chandler was part of a scheme to defraud the Medicaid program by recruiting beneficiaries to his clinic and writing multiple prescriptions in each beneficiary's name. The pharmacies then allegedly billed Medicaid for the prescriptions without dispensing them to the named beneficiaries, according to prosecutor Greta Gooden Brown. Chandler faces three to five years in prison when he is sentenced and more than \$100,000 in restitution for all payments made by Medicaid to the clinic since it opened in 2007. He also will be barred from participating in the New Jersey Medicaid program for five years. Visit [www.nj.gov/oag/newsreleases08/pr20080828b.html](http://www.nj.gov/oag/newsreleases08/pr20080828b.html).

◆ **Effective July 17, claims on which the servicing provider ID is the same as the billing provider ID will be denied by Computer Sciences Corporation's eMedNY billing system**, according to a July 2008 New York Department of Health Medicaid Update. The update states that only provider claims containing provider identifiers that are different than billing providers' IDs will be paid. Providers' remittance statements will identify denied claims as Edit 1357 denials. Solo practitioners that bill for their own services are advised to leave the servicing provider field on claims blank. For more information, contact CSC Provider Relations at (800) 343-9000, or go to [www.health.state.ny.us/health\\_care/medicaid/program/update/main.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm).

◆ **A man charged with recruiting homeless Medicaid and Medicare beneficiaries and sending them to Los-Angeles area hospitals as referrals has entered a plea agreement**, according to the U.S. Attorney's Office for the Central District of California. Estill Mitts owned an "assessment center" and referred beneficiaries to hospitals that allegedly would then send him illegal payments for the referrals, the government said. The hospital services were not needed and, in some cases, never provided, it alleged. Mitts pleaded guilty to conspiracy to commit health care fraud and faces 25 years in prison. Visit [www.usdoj.gov/usao/cac](http://www.usdoj.gov/usao/cac).

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