

HEALTHCARE JOURNAL

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**Fraud Strike
Force Targets BR**

**OR Turnaround
Tackled**

**Baton Rouge
Gets Moving**

**One on One
with Bruce Greenstein
Secretary, DHH**

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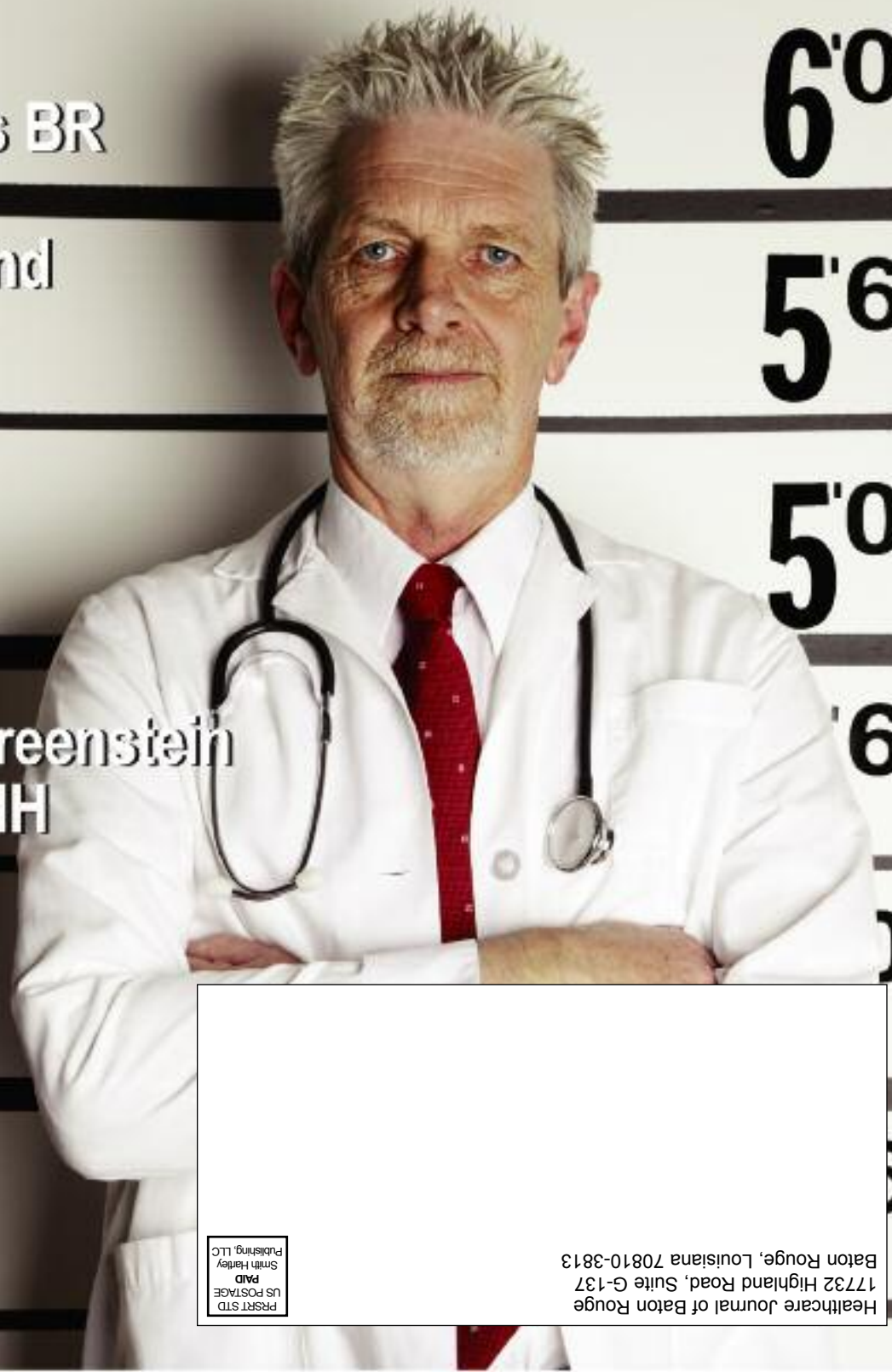
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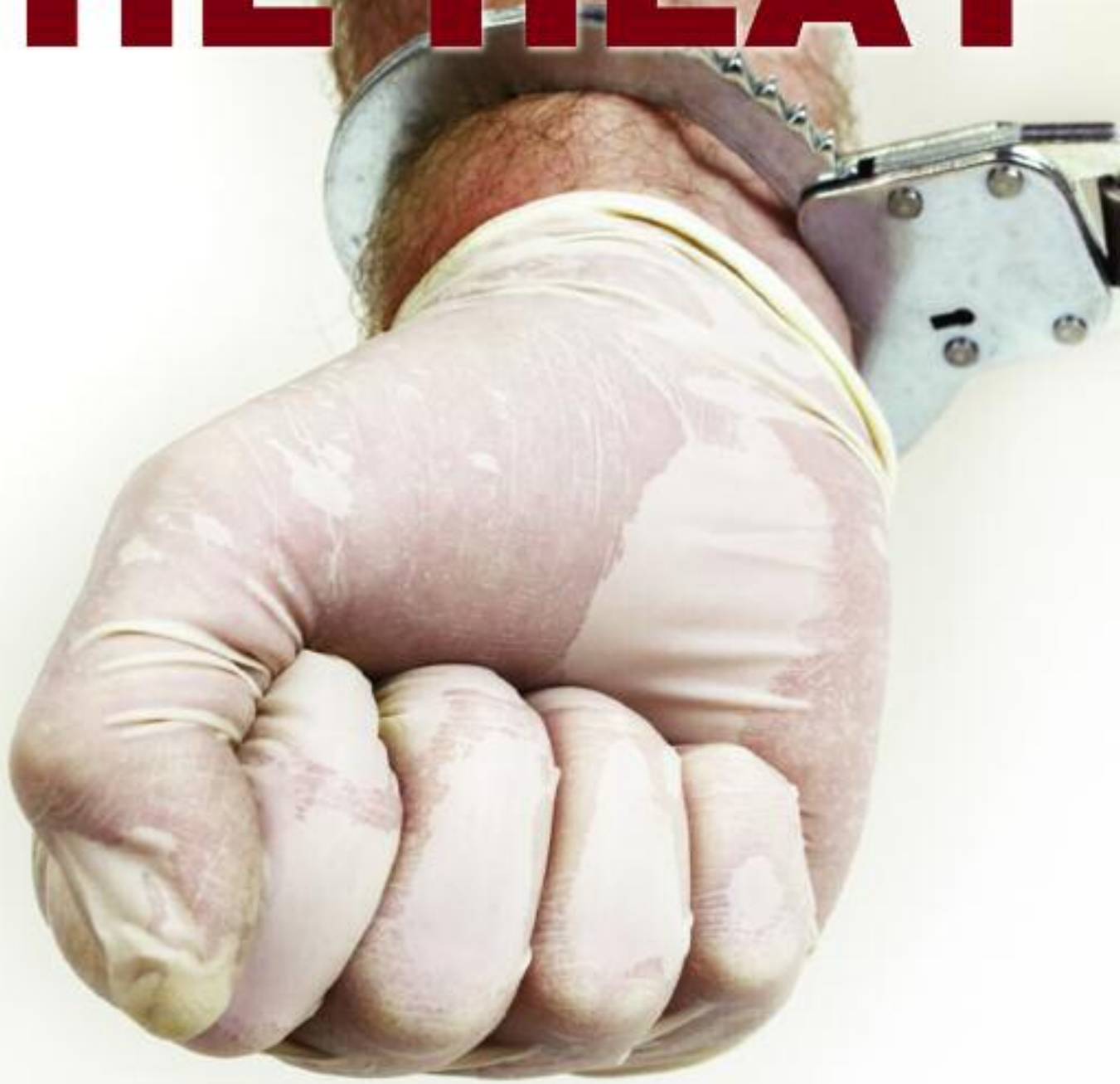
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BRINGING THE HEAT



MEDICARE STRIKE FORCE TARGETS BATON ROUGE

by: Karen Stassi



I

In the ever present, anxious dialogue concerning rising healthcare costs, one of the most frequently mentioned factors is fraud, particularly in the Medicare and Medicaid programs. Estimates are that fraudulent claims and practices account for 3 to 6 percent of the nation's healthcare costs. That doesn't sound so bad unless you consider that percentage in the context of the billions of dol-

lars we spend on healthcare in this country. Efforts to shore up both Medicaid and Medicare to cover those losses affect patients, providers, and the healthcare system in general. Recently, in an effort to crack down on these staggering losses, the U.S. Department of Health and Human Services (HHS) and the U.S. Attorney General's office created Medicare Fraud Strike Forces in certain cities where fraud was most rampant. That large cities like Houston, Los Angeles, and Detroit were targeted surprised nobody. The fact that Baton Rouge was one of the first to attract the attention of a strike force, however, was a bit of a shock.

Bill Root, a special agent with the HHS Office of the Inspector General (OIG) and a member of the Baton

rouge Strike Force, acknowledged that people are surprised to find that Baton Rouge was specifically targeted, but said the selection was completely data driven. And the data, particularly for claims concerning durable medical equipment (DME), suggested that something was very wrong in the heart of Red Stick.

The data, we are sad to say, was correct. Within just a few months of operation, the strike force announced 31 indictments of 29 defendants in the Baton Rouge area. Root, who has been in the area for 23 years, said that represents more indictments than in the past 20 years combined. The cases involved more than \$35 million in fraudulent claims to Medicare. And the strike force is far from being done, said Root. In fact, it will remain in operation in Baton Rouge until the data show that the city's Medicare claims are more in line with expectations. However there is a light at the end of the tunnel.

"In a city the size of Baton Rouge, my personal experience tells me the strike force will not last as long here as it's going to last in Miami, Houston, or Los Angeles, just based on the raw numbers of providers and beneficiaries," said Root. "That problem is going to continue in those cities longer than I think we can make a real dent in the fraud problem in Baton Rouge."

The collaborative nature of the Medicare Fraud

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ment's response to criminal fraud, decreasing by roughly half the average time from an investigation's start to the case's prosecution, according to DOJ.

In addition to the money saved by rooting out and prosecuting fraud perpetrators, the strike forces act as a deterrent for future fraud. So far, the effect of that deterrent has been hard to quantify, but the numbers of fraud cases have significantly decreased in cities with strike forces in place. Post-strike force data from Baton Rouge is currently being compared to pre-strike force numbers, but Root is certain the presence of the strike force and the public announcement of indictments are having a deterrent effect on would-be bad actors. "I feel very confident that it's going to show a tremendous decrease in the numbers of DME cases that we are investigating," said Root.

While the strike force is mining data on all kinds of Medicare fraud, it was Baton Rouge's unusually high rate of claims for DME such as power wheelchairs that first caught regulators' attention. Root explained that because the Medicare program is set up to help people in need, it makes it easy for a provider to participate in the program and to get quick turnaround on reimbursement. "By doing that, Medicare doesn't have a chance to actually screen the claims. They pay them and then we go and



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A Compliance Program Can Help Fight Fraud

Establishing and following a compliance program can help physicians avoid fraudulent activities and ensure that they are submitting true and accurate claims. The following seven components provide a solid basis upon which a physician practice can create a voluntary compliance program:

- Conduct internal monitoring and auditing.
- Implement compliance and practice standards.
- Designate a compliance officer or contact.
- Conduct appropriate training and education.
- Respond appropriately to detected offenses and develop corrective action.
- Develop open lines of communication with employees.
- Enforce disciplinary standards through well-publicized guidelines.

With the passage of the Patient Protection and Affordable Care Act of 2010, physicians who treat Medicare and Medicaid beneficiaries will be required to establish a compliance program.

For more information on compliance programs for physicians, see OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" available at <http://oig.hhs.gov/authorities/docs/physician.pdf>.

screen and chase the money," said Root. "Unfortunately it's a pay and chase system that we're faced with on the law enforcement side." DME claims were already given only a cursory review before being paid, so were an easy target for scammers. Then, when hurricanes Katrina and Rita hit the Gulf South, Medicare further expedited those claims to replace chairs lost or damaged in the storms. Even the minimal review fell by the wayside in an effort to get people their equipment quickly. With so many people displaced and addresses and health records difficult to verify in the years following Katrina, the opportunities for fraud were rife.

So how exactly does the strike force work? Generally a fraud investigation is launched based on aberrant data or on a report from a whistleblower. The first step, said Root, is to go interview the beneficiaries to make sure the care or the equipment was actually delivered. Investigators will also make sure patients received the same equipment for which Medicare was billed. Often providers will bill Medicare for a higher end chair than the patient received in order to boost their profit margin.

The image shows a Medicare Health Insurance Claim Form (Form 1500) with various fields filled out. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes sections for "PATIENT INFORMATION", "PROVIDER INFORMATION", "SERVICE INFORMATION", and "BILLING INFORMATION". The form is tilted and appears to be a scan of a physical document.

Investigators also evaluate whether the equipment was truly medically necessary. "If I come to your house and you are not finished with your six-mile morning run, well that's a pretty good clue you didn't qualify for that power wheelchair," said Root. The next step is to visit the beneficiary's primary care physician to check if the chair was medically required and if it was actually prescribed by that physician. Sometimes there is a second physician who wrote the referral or prescribed the treatment or equipment, but in many fraud cases, that physician never evaluated the patient in person. Instead the physician is being remunerated by the DME provider for providing the fraudulent prescriptions.

Root said there are also several instances where the item or service in the claim is never delivered. A claim for a wheelchair is submitted to Medicare, but the patient listed didn't actually receive one. Fraudulent providers count on minimal oversight to reap pure profit. Root indicated that there is also a tremendous markup in the prices Medicare pays for the wheelchair versus what the medical equipment companies can get the chair for. The markup covers differences in quality and sometimes an included maintenance plan. "Unfortunately for these patients they get these chairs from these disreputable equipment dealers and when they need some service they can't find anybody to help them," said Root.

Before the practice attracted the scrutiny of these strike forces, the minimal risk to providers was worth it in exchange for easy profits. However, the increased focus on fraud at the federal level appears to be working to weed out the bad actors. In 2009, the DOJ reported that nationally, criminal healthcare fraud charges were filed against more than 800 defendants and 583 criminal convictions were secured. There were 886 new civil health care fraud investigations and 337 civil administrative actions against individuals or organizations. More than \$2.5 billion was recovered in criminal, civil, and administrative actions.

While most fraud cases are initiated based on discrepancies in data, whistleblowers are another important part of the anti-fraud effort. Whistleblowers can be the patients themselves or their family members, other providers, or employees. "The beneficiaries are a valuable resource to us as well as the other providers in the medical community," said Root. "There are a lot of good patients and a lot of good providers and they are very valuable in directing us to what direction we should be looking in to identify potential fraudulent providers." In an effort to encourage whistleblowers HHS has increased educational efforts for both beneficiaries and providers to explain what constitutes fraud and how to report it. One of the primary

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efforts has been the Senior Medicare Patrol where Medicare beneficiaries are urged to report any discrepancies they notice. The Baton Rouge strike force meets with this group regularly to disseminate fraud, waste, and abuse information to the Medicare community and to make sure they know who to call.

Providers are also being educated on how to recognize and avoid fraud. Anyone who has ever filled out a Medicare claim knows that the potential for error is high. Making a mistake is not fraud, but submitting a claim that you know or should know is incorrect is, even if you have no intent to defraud the government. Some of these cases are resolved as waste or abuse, which carry their own penalties, but OIG opens each of its cases as a criminal investigation, especially those involving these strike force investigations, said Root. "If there truly is no intent to defraud that can be proven then it could be handled either by a civil action or an administrative action," said Root. "There are billing errors. Not everything is fraud. If it was just abuse or neglect, just a plain out error, then we will handle it administratively or civilly with a fine." While the fine beats a criminal charge, it can still be quite hefty. Even without intent to defraud, submitting false claims can result in penalties up to three times the program's loss plus up to \$11,000 per false claim.

However, for those convicted of fraud, the consequences are much worse. For example, physicians submitting false claims in exchange for kickbacks face fines of up to \$50,000 per kickback, plus penalties of three times the amount of the kickback, possible jail time, and administrative sanctions. In addition, convicted

tal proceeding. Several Medicaid provider agreements were summarily terminated by the Louisiana DHH last year when providers were convicted of Medicare fraud.

In its latest effort to educate providers OIG decided to reach out to physicians while they are still in medical school. The office recently published a brochure for medical students outlining the pitfalls of Medicare and Medicaid fraud and how to avoid it. The brochure, "A Roadmap for New Physicians" explains the various statutes to which providers are subject as well as the various temptations and inducements they may encounter from colleagues, equipment companies, and pharmaceutical reps. The brochure acknowledges that some of the lines can get blurry and advises students to get professional guidance on decisions that could draw scrutiny. The roadmap also urges physicians to self report if erroneous or fraudulent claims have been made. It's not an amnesty program; penalties will still be incurred, but the consequences are significantly less than if a federal investigation is initiated as a result of a discrepancy or a whistleblower report.

Gone are the days of hoping CMS won't notice if a claim is a little off. In the Spring of 2009, concerned about the continued solvency of Medicare in the wake of staggering numbers lost to fraud, Health and Human Services (HHS) Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new initiative aimed at combating healthcare fraud. The Health Care Fraud Prevention and Enforcement Action Team, dubbed HEAT, was designed to increase collaborative efforts to combat fraud, waste, and abuse and to crack down on

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providers can no longer participate in Medicare. For some providers, such as DME and home health providers, Medicare is often their primary source of income. Exclusions can range from a minimum of five years to a permanent ban. In addition, reputable providers may not do business with those convicted of Medicare fraud. "That's the right thing to do," said Root. "If you get caught cheating the system why should you get to participate in the system? I think most of the medical community agrees with that." In addition, state law allows the Secretary of the Department of Health and Hospitals to terminate provider agreements immediately and without written notice if a health care provider is the subject of a sanction or of a criminal, civil or departmen-

tal proceeding. Not only has HEAT boosted the range and efficiency of the strike forces, but the Patient Protection and Affordable Care Act of 2010 will assist in those efforts. The act calls for additional agents to investigate fraud starting this year. The act also enhances data sharing between federal agencies and strengthens civil and monetary penalties for fraud cases. In addition, in 2013, vendors and providers will have to publicly report all gifts and incentives given to physicians.

Root said his office considers physicians as the true gatekeepers of the Medicare program. "The physicians determine who gets what services and who gets what products," he said. "We need the physicians to be more careful as to the services and products they do pre-

We need the physicians to be more careful as to the services and products they do prescribe and to report any violations or suspicions of fraudulent activity to our office. -Bill Root

scribe and to report any violations or suspicions of fraudulent activity to our office.” He added that the rest of the medical community sees just as much and they can also take it upon themselves to reach out and notify his office of any suspicious or fraudulent activity that they are aware of. “I believe the medical community does a lot already, but could do even more to help clean up the fraud, waste, and abuse in the healthcare programs,” said Root.

Have questions? Need to report fraud? You can contact the local OIG office at 1-800-447-8477 or 225-298-5441 or you can find more information at <http://www.stopmedicarefraud.gov/>. ❖

Sources: Russo, Tracy, “HEAT: A Year of Tackling Health Care Fraud,” *The Justice Blog*, U.S. Department of Justice, <http://blogs.usdoj.gov/blog/archives/934>; “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud & Abuse” U.S. Department of Health & Human Services, Office of the Inspector General; “Annual Report for Fiscal Year 2009,” *Health Care Fraud and Abuse Control Program*, Department of Health & Human Services and The Department of Justice, May 2010

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