

MEDICAID COMPLIANCE NEWS

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

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CMS Ramps Up Medicaid Provider Scrutiny; Expert Sees a 'Sea Change' in Enforcement

Providers nationwide will increasingly feel the heat from Medicaid auditors now that the Medicaid integrity program is in full swing and state program integrity officials are receiving "state-of-the-art training" from the federal law enforcement training center, according to Robb Miller, director of the Division of Field Operations in the CMS Medicaid Integrity Group. By December, he said recently, providers in every region of the country, though not necessarily every state, will face federal Medicaid auditors.

Some 750 Medicaid Integrity Contractor (MIC) audits are now underway in half the states, Miller said Nov. 3 during a Health Care Compliance Assn. audioconference, and so far those audits have identified \$24 million in overpayments. For example, he explained, "we found hundreds of instances where a state paid the professional component of radiology services to both the radiologist and the hospital," resulting in \$5.5 million worth of overpayments.

CMS has contracted out Medicaid integrity work to "review" MICs, which do data mining; "audit" MICs, which target providers based on leads from the review MICs; and education contractors, which inform providers and beneficiaries about payment integrity and quality-of-care issues. The MICs use hundreds of algorithms — which are the heart of data mining — to identify aberrant billing and zero in on suspicious behavior, Miller told listeners. "Some of our algorithms," he said, "produce results that potentially involve thousands of claims, and there is some backlash."

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Vt. Psych Hospital Gets Help in Seeking Recertification Amid Differing Agency Views

Vermont State Hospital (VSH) may get another chance at CMS recertification — after four years without a dollar of funding from federal health care programs — thanks to a Washington, D.C., gathering of power players from the health care and political sectors. The Oct. 20 meeting was called in part because of conflicting survey results in 2008. While the Department of Justice (DOJ) found the hospital in compliance and the Joint Commission granted accreditation, CMS cited patient-care issues and withheld eligibility for Medicaid and Medicare reimbursement.

The state's only public psychiatric hospital has been in hot water with the government for years. It first lost CMS certification in 2003, after two patients hanged themselves within 30 days of each other. Michael Hartman, commissioner of the Vermont Department of Mental Health, says that there were "poor practices in terms of patient supervision" at the time, as evidenced by a CMS survey conducted a few months before the suicides, and it was a "mutual agreement" with HHS that the hospital be decertified. In late 2004, the hospital regained certification, only to lose it in early 2005 after a patient left the facility without staff knowing, which aroused renewed concern on the part of CMS. Again, VSH did not contest the decertification.

continued

Patient-care issues at the 54-bed hospital also spurred an investigation in 2004 by the Civil Rights Division of DOJ. A letter from Gov. Jim Douglas (R), dated July 2005, states that the “conditions and services at VSH substantially depart from generally accepted standards of care, and violate the constitutional and federal statutory rights of patients.” DOJ determined that VSH failed to protect patients from harm and undue restraints, provide adequate mental health services and plan appropriately for patient discharge. Hartman says that the hospital settled out of court and agreed to implement reforms to “avoid going to federal court.”

According to Hartman, the hospital spent the next two years funneling money into staffing and resources in hopes of regaining Medicaid and Medicare reimbursement. By 2007, he says, the hospital’s budget had doubled — all on state dollars — and there was a 40% increase in staffing, “the establishment of a better medical-record system” and other quality-related improvements.

DOJ returned several times in 2008, says Hartman, and “indicated that we had made very good progress

on improving conditions. Based on that feedback, we applied for [Joint Commission] accreditation and [CMS] certification.” The hospital received accreditation from the Joint Commission. CMS denied certification, citing patient-care concerns and building safety hazards (see illustration, p. 3).

Ken Powers, spokesman for the Joint Commission, says accreditation is based on nationally developed standards and accounts for “the entire continuum of patient care, from medication management to the actual physical environment to security alarms to pretty much you name it, and our standards address those things.”

He says that although CMS and the Joint Commission are separate entities, they do cooperate and share information. The Joint Commission doesn’t have regulatory authority like CMS, but it does have “deeming” authority, which means that in most cases “CMS recognizes Joint Commission accreditation as meeting the standards for reimbursement.” Powers is not familiar with the specifics of the VSH case, but says, “It is possible for a hospital to have Joint Commission accreditation but not be certified by CMS, although we do not track how common that is.”

Old Problems Were Replaced by New Ones

CMS returned for another survey in April 2009 and found that VSH had cleared up its previous deficiencies. However, the inspection evidenced a shorter list of new problems that precluded certification, including unmet fire-safety standards and several instances in which patients had injured themselves with pieces of plastic. In May 2009, VSH issued a plan of correction to CMS that included a list of objections to the deficiencies and a letter expressing concern that none of the surveyors on the CMS team had psychiatric training.

Three months later, CMS was back again to check on progress. The July 2009 statement of deficiencies indicates that the previous problems had been taken care of but that a recent situation demonstrated that the facility “failed to provide and maintain an environment that would assure patient safety and well-being.” Weeks earlier, hospital staff discovered that one patient had managed to stash a collection of items, including 52 Tylenol, nine rolls of toilet paper and 30 small boxes of cereal in his room. According to the HHS report, “No hospital-wide actions were taken by the nursing department as a result of this incident,” including no retraining on doing mouth checks for medication and no changes in daily room-check procedures. Hartman says the patient, when interviewed, claims he saved the items because he was expected to be discharged in the next few days and didn’t have any money.

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After the July survey, Hartman says, CMS told the hospital it could no longer just implement a plan of correction, but would have to start from ground zero in applying for certification. That’s when Douglas got involved, according to Hartman, and called Cindy Mann, director of CMS’s Center for Medicaid and State Operations. “Not that the hospital should be rubber-stamp approved, but it seemed to be conflicting that DOJ had come in May and was mystified why we weren’t approved,” says Hartman. It seemed clear there “was a higher bar [Boston’s CMS office] was looking for. It’s not clear how high the bar was, but higher than would be expected for a hospital to meet. We were convinced we’d reached a level acceptable for certification.”

According to Hartman, after the governor’s call, his department got a call from the Boston office “stating that if we wanted to send a letter to say we felt we were in compliance, CMS could produce another survey.” Instead, the politicians stepped in again. U.S. Sen. Bernie Sanders (I-Vt.), who’d been in contact with Hartman and

several state lawmakers over the issue, opted to convene a face-to-face with Mann and her staff.

On Oct. 20, Hartman flew down to D.C. to meet with Sanders and his aides; Mann; Angela Brice-Smith, deputy director of surveys and certification for CMS; and Josh Phillips, a CMS legislative affairs staffer. Vermont state senators Susan Bartlett (D) and Diane Snelling (R) joined in over the phone. According to Sanders’ press secretary, William Wiquist III, “The senator decided to convene this meeting because Vermont State Hospital is the only state mental hospital in Vermont, and it has not been certified for several years.” A press release from Sanders’ office quotes him as saying that “the state is losing out on \$10 million a year in federal reimbursement.”

The meeting lasted an hour and 15 minutes and was “amiable,” says Hartman. “We tried to assure them that where the hospital was in 2003 was a bad place and that we were not contesting [that CMS] needed to have taken action then.” The group also discussed the fact that

Examples of Violations at Vermont State Hospital From HHS’s Statements of Deficiencies (SODs)

<p align="center">From 9/18/08 SOD</p> <p><i>(Standards were not met for a total of 26 conditions)</i></p>	<p align="center">From 4/9/09 SOD</p> <p><i>(Standards were not met for a total of 15 conditions)</i></p>	<p align="center">From 7/29/09 SOD</p> <p><i>(Standards were not met for a total of 3 conditions)</i></p>
<ul style="list-style-type: none"> • Metal pipes posed risk for strangulation • Pictures affixed with screws that were not vandal-proof • Sinks with angled faucets could support weight during a suicide attempt • Curtains had brass tension rod that could be used as a weapon • Staff members failed to monitor bathrooms • No mechanism for reporting to CMS deaths that occur during restraint/seclusion • Failure to ensure medical records were secure, accessible and complete • Drugs and biologicals stored in place accessible to unauthorized staff • Outdated and unlabeled drugs available for patient use • Kitchen improperly sanitized • No written protocols concerning organ procurement • Grievance and appeals process lacked procedure for referring beneficiary concerns to Quality Improvement Organizations • No written policies on respiratory care safety practices and scope of respiratory care 	<ul style="list-style-type: none"> • Patient repeatedly able to obtain and hide plastic spoons and harm self • Patient supposed to be under constant supervision broke plastic cap off shampoo bottle in shower and lacerated self • No safety inspection conducted after a patient obtained loose screws from furniture • Paging speakers on wall not loop proof • Smoking porches had exposed pipes and link fence • Psychiatrist’s credential file did not contain peer references • Patient’s oxygen saturation levels not documented • Utilization committee reviews conducted by physicians that participated in the treatment • Nurse wore contaminated gloves, did not wash hands • Doors had gaps at the door stop in excess of allowance for sprinklered building • No fire damper in elevator machine room • Telephone closets lacked sprinkler protection • Dry pipe fire system had not been tested in 5 years 	<ul style="list-style-type: none"> • No full-staff retraining took place after a patient obtained and hid the following items: -52 Tylenol -1 Excedrin -16 Protonix -aluminum foil -candy -sandwiches -20 tongue depressors -9 rolls toilet paper -4 cans of Boost -cheese and crackers -30 boxes of cereal -5 boxes of tissues

CMS's determinations did not line up with those of other surveyors, including DOJ, which confirmed the hospital was making progress and meeting quality standards.

"We ultimately agreed to disagree as to whether the hospital should've been held to that standard or not," says Hartman. "More important is what should happen now: Mann made clear that from her perspective we had made significant changes and she was feeling supportive of having a survey to confirm that we'd addressed the issues" from the previous survey. The hospital submitted a letter requesting a new survey on Oct. 30 and is awaiting CMS's arrival.

Wiquist tells MCN that CMS will "now likely make an unannounced inspection within 30 days. Pending the

results of that inspection, they would come again within 120 [days] to check it again." Under that timeline, he says, "recertification could happen in the spring."

Roseanne Pawelec, spokesperson for the Boston regional office of CMS, says, "The hospital is reapplying for admission. As part of the application process, there will be a new survey. It would be inappropriate to comment further at this time."

For Hartman, the events bring up the concern that under new enforcement efforts, CMS standards may be understood differently by different parties. "There's been a swing back to be fairly conservative about what passes [for certification]," he says. "The regulations haven't changed; the interpretations haven't changed. We're being told there are no changes, but the outcomes indicate something different."

And while a hard-line approach may have "great validity when talking about cleanliness and procedures," things aren't always so black and white in a psychiatric setting, according to Hartman. "There's a risk that CMS is going too far in trying to establish risk-free environment for psychiatry."

Contact Hartman at (803) 652-2000. ✧

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- ✓ **High-Risk Areas in Medicare Billing**, which is packed with "how-to" compliance auditing tools for hospitals and providers that were prepared by experienced compliance consultants from Strategic Management Systems, Inc. See a demo at www.MedicareRiskAreas.com.
- ✓ **Report on Patient Privacy and AIS's HIPAA Compliance Center** will help safeguard your patient privacy and data security. Subscriptions include a monthly print newsletter and access to a Web site — with narrative sections written by HIPAA experts in 30 areas of privacy and security compliance. Review samples at www.AISHIPAA.com.
- ✓ **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.
- ✓ **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.
- ✓ **49 Steps to Implement Sarbanes-Oxley Best Practices in Private & Nonprofit Health Care Entities**, a highly practical book that identifies and describes steps for adopting consensus best practice standards (includes a free CD with templates).

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Virginia Psych Facility for Boys Faces Claims, Quality Charges

The U.S. Department of Justice (DOJ) and the Commonwealth of Virginia have intervened in a False Claims Act lawsuit against Medicaid providers Universal Health Services Inc., Keystone Marion LLC and Keystone Education and Youth Services LLC. The entities do business as the Keystone Marion Youth Center, a residential facility in Marion, Va., that receives Medicaid funds to provide psychiatric counseling and treatment for boys ages 11 to 17. Indeed, in their complaint, the "relators" allege that "with only a few exceptions, the defendant restricted admission to the Youth Center to patients who would qualify for reimbursement of the medical costs under the Medicaid program."

The suit was filed by "several former therapists," DOJ says, who worked at the Marion residential facility. It alleges that the defendants "provided sub-standard care to adolescents in violation of federal and state Medicaid requirements, falsified records to cover up their serious violations and filed false Medicaid claims." Under the False Claims Act, a health care provider that submits false or fraudulent claims to a federal health care program is liable for three times the government's damages, plus a civil penalty for each false claim. The allegations in the lawsuit include:

◆ **Billing for services for residents for which there was no supporting documentation that the services were provided.** Specifically, the relators allege, the facility “billed Medicaid for the treatment of certain residents even though the 30-day reports” — required Medicaid reviews — “therapy progress notes, master treatment plans, treatment plan reviews and other [types of] documentation for those residents that were prerequisites for Medicaid reimbursement were nonexistent and/or missing.” The facility’s leadership said that was done, the lawsuit alleges, “as an effort to reduce therapists’ work loads.” In another instance, the lawsuit alleges, a facility administrator instructed a therapist to complete a 30-day report for a patient “to whom [the therapist] had only given two of the 36 sessions required for Medicaid billing.”

◆ **Regularly conducting group-therapy sessions scheduled for 50 minutes for only 10 to 20 minutes,** but billing for the full 50 minutes.

◆ **Billing a “drive-by” five-minute interaction with a resident in a hallway or public room as a 30-minute individual therapy session.**

◆ **Provoking — “escalating,” in psychiatry-speak — residents** so that their reactions would serve to justify a longer stay, to increase Medicaid reimbursement.

◆ **Billing for therapy sessions conducted by an unlicensed therapist** when that therapist was no longer under supervision toward licensure.

◆ **Having non-clinical staff improperly alter therapists’ records in ways that would justify or increase Medicaid reimbursement.** Specifically, the lawsuit alleges, one administrator “demanded that all therapists provide their computer passwords, which would allow [the administrator] or other unauthorized persons to rewrite therapists’ reports after they had signed and submitted the documentation.” Also, the lawsuit alleges, an administrator “demanded that therapists remove page numbers from their reports to facilitate other staff members’ turning in delinquent reports and/or making it less noticeable to the therapists and to Medicaid that sections of their reports were being recreated by non-clinical staff.”

◆ **Delaying the discharge of residents to increase Medicaid reimbursement.** Those discharges, the suit alleges, “were delayed to the beginning of the next month because Medicaid would pay through the end of the month and the occupancy levels would reflect the expectations of the corporate office.”

◆ **Deliberately understaffing the Youth Center so that it was impossible to comply with Medicaid standards** without all of the therapists working an average of at least 60 hours a week — which they did not do.

Furthermore, the lawsuit alleges, one administrator “ordered the therapists to use ‘creative writing techniques’ in their reports to exaggerate those aspects of a resident that would support diagnoses that would justify a longer stay.” Also, it charges, the facility “encouraged therapists to falsify documents by writing therapy notes for sessions that did not occur, to create therapy notes for the male therapists” — there are sex and race discrimination charges included in the original complaint — “for sessions that were not completed, to complete reports for patients who had not yet been seen for therapy and to falsify many aspects of reporting in the documentation.” One of the relators says a supervisor “requested that [the relator] change the reporting periods on reports that were more than one year old to dates less than one year old so [the facility] could submit a request for reimbursement from Medicaid for those services.”

In addition, the lawsuit alleges that the facility “instructed therapists to include more than 10 patients in therapy groups, even though Medicaid regulations limited the group to 10.” Moreover, the complaint says, “the group never appeared to take place, as floor staff reported that those patients were left in their units while all others were taken to scheduled group therapy sessions, and Medicaid was billed for those non-existent therapy groups.” Finally, the complaint alleges, the relators “were provided with identification badges that were used to swipe through the time clock to document work hours. [They] were instructed to only swipe once daily, upon arrival. [Later,] they were asked to swipe twice a day at any time. Then it was a change back to swipe only once a day — making it impossible for administration to document the amount of hours for any employee during a given day.”

The facility says none of it is true. “Marion Youth Center denies the allegations contained in the False Claim Act litigation filed in the Western District of Virginia,” Rick Bridges, CEO and managing director there, tells MCN. “We intend to defend this case vigorously to demonstrate that Marion Youth Center did not engage in any fraudulent practices as alleged. Further, Marion Youth Center has always provided high-quality psychiatric care to our residents and specifically disputes any allegations that our residents received ‘sub-standard’ care.”

Contact DOJ’s Charles Miller at charles.s.miller@usdoj.gov and Bridges at (276) 782-1990. ♦

Politicians’ Wish for Tougher Medicaid Policing May Come True

Politicians of all stripes — from the Obama administration and New York Gov. David Paterson (D) to GOP candidates for governor and attorney general elsewhere in the nation — are making tougher Medicaid fraud enforce-

ment a key component of their election campaigns and public-policy pushes. And hospitals and other providers should take note. It's not just election-year noise, experts tell *MCN*. The Medicaid program is a fair target for more aggressive anti-fraud activity, they say, and there's plenty of illegal and inappropriate activity yet to be rooted out.

There does seem to be an expectation among most politicians that increased health care fraud enforcement can cover much of the increased cost associated with health reform, notes attorney Linda Baumann, a partner in the Washington, D.C., office of Arent Fox LLP. But at what cost? "I think most providers are trying to do the right thing, and support anti-fraud efforts, at least in theory," she says. "However, on a practical level, they have often found that increased fraud enforcement efforts require them to devote substantial time and money to respond to investigations and litigation, some of which may be unfounded — if, for example, there was no problem or perhaps there was a clerical error and something was billed incorrectly, but there was no improper intent."

Laws on Fraud Said to Favor Government

Indeed, she points out, "there is likely a point where the cost of chasing alleged fraud becomes more expensive than the potential for recovery." But she notes as well that "the laws and penalties are structured in the government's favor." If it can recover treble damages plus per-claim penalties under the False Claims Act, for example, the government "probably doesn't have to succeed in every case to come out ahead," Baumann says. "That's why the government can say it recovers \$13 — or whatever the figure is now — for every dollar spent on fraud enforcement. Moreover, because the government has the power of exclusion, almost no one litigates those cases — they almost always settle." She adds: "I don't think the government's figures take into account the tremendous amount of money that providers are spending on compliance and defending themselves against such investigations and litigations. Those costs are being passed on to the consumer, if not to the government."

Richard Kusserow, CEO at Strategic Management in Alexandria, Va., sees less gray area when it comes to aggressive Medicaid fraud prosecution. He was the Inspector General at HHS for 11 years. "I can categorically state that Medicaid is a fair target," he says. "It does not let Medicare off the hook; fraud in Medicaid is many times the level of fraud in Medicare. The emphasis on fraud-fighting is not something created as an election-year ploy."

What it is, he says, is perhaps the best the government can do with a program as complicated as Medicaid. "Abuse for hospitals arises from the fact that Medicaid beneficiaries treat them like clinics, clogging the service system with non-acute care problems," he tells *MCN*.

"Until there is a public will to focus on Medicaid beneficiaries as the prime factor for increased health care costs, there will be little to alleviate the problem." But prosecuting Medicaid "cheaters" is "not a popular notion," he says, "and does not result in monetary recoveries that actions against providers can produce."

And even if fraud prosecution increases dramatically, he emphasizes, there's little chance that innocent providers will be unfairly harassed. "The basis for an investigation must have substance and be anchored in evidence suggesting wrongful behavior," Kusserow explains. "Investigators just don't go out on fishing expeditions. They don't have the authority to do that, and it could result in legal action if they were to proceed without adequate grounds." And he doubts there's a limit, realistically, to how much more can be wrung from the Medicaid program through fraud enforcement. "The Deficit Reduction Act of 2005 included net reductions of \$4.8 billion over the ensuing five years and \$26.1 billion over the ensuing 10 years from Medicaid," he notes. And that's just the expectation from one law, he adds. It's not anyone's estimation of the total amount of fraud in the system.

The enhanced focus on fraud-fighting might actually be worse news for nursing homes and others in the health care sector than for hospitals, says Bill Moran, senior vice president at Strategic Management's Chicago office. "Over a third of the money in Medicaid is spent on long-term care, primarily nursing homes, which have had a long history of fraud, waste and abuse," he says. "Also, the managed care providers need to be looked at more closely. With the increased funding for Medicaid Integrity Contractors, more of those providers will be looked at, in addition to fee-for-service providers."

Contact Baumann at (202) 857-6239 or baumann.linda@arentfox.com, Kusserow at (703) 683-9600 or rkusserow@strategiccm.com and Moran at (847) 828-3515 or wmoran@strategiccm.com. ♦

N.Y. OMIG Reports Savings, Details Compliance Program Rules

New York's highly regarded Office of Medicaid Inspector General (OMIG) posted record-breaking "cost avoidance" numbers for calendar 2008, and its head, Jim Sheehan, says the numbers for 2009 should be even bigger. In the long run, he adds, the savings figures should start to drop, however, as providers get the multitudes of messages OMIG sends out about how to better manage Medicaid compliance.

OMIG succeeded in saving the state \$1.66 billion — including nearly \$134 million in recipient restrictions — during 2008, the entity's latest Annual Report asserts. And during federal fiscal year 2008, which ran from Oct.

1, 2007, through Sept. 30 of last year, OMIG met and exceeded federal identification and recovery requirements under the Federal-State Healthcare Reform Partnership (F-SHRP). The goal was \$215 million, and, in collaboration with OMIG's state-agency partners — especially the New York state Office of the Attorney General (AG) — Sheehan's shop recovered \$551 million.

"A major part of OMIG's mission is identifying, preventing and recovering improper Medicaid payments due to fraud, waste or abuse," Sheehan tells MCN. One example, he notes, were those "recipient restriction" savings, achieved by "placing restrictions on some recipients — restricting them to one primary care provider, one pharmacy provider or one hospital, for example." For the F-SHRP program, he adds, OMIG "worked in collaboration with our agency partners, including the AG and the New York State Department of Health. We use sophisticated data-mining techniques and have millions of pieces of information against which we can compare incoming information to identify potential fraud, waste or abuse."

Next time around, Sheehan adds, OMIG expects results to be similar to 2008's. "For federal fiscal year 2010 — which started Oct. 1 and runs through Sept. 30, 2010 — our required F-SHRP target is \$429 million," he reports. "We expect to meet or exceed that goal." It's difficult to predict where OMIG will be on the cost avoidance front, he says, "although we expect our numbers to

be higher than last year's." Over the long term, he emphasizes, "we are focusing on prevention and stressing integrity on the front end, and we would expect to see our recoveries decline because providers are addressing their compliance issues."

Here are highlights from the OMIG Annual Report:

◆ **OMIG excluded 660 providers from participating in the Medicaid program** in calendar year 2008, and terminated 39.

◆ **OMIG referred 531 cases to other state agencies**; the vast majority of which, 496, were referred to local social services districts for investigation at the local level.

◆ **OMIG auditors initiated 2,532 audits and completed 1,738.**

◆ **OMIG began 3,281 investigations in 2008 and completed 2,366.** In 2008, 921 investigations began as the result of information OMIG received from the fraud hotline.

◆ **OMIG initiated 67 fraud financial investigations** (see table, below) and finalized 58 of them. The Division of Medicaid Investigations (DMI) "deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services and cooperating with other agencies to enhance enforcement opportunities," the Annual Report says. The DMI includes the Provider Investigations Unit, the

Total Medicaid Fraud Financial Investigations by New York State in 2008

Project Type	Initiated	Finalized	Findings	Recoveries
Annual Ambulette Survey	26	26	\$ 0	\$ 15,314
Billing Issue	10	1	741	331,377
Court Decision	1	1	475	475
Credential Verification Review (CVR) – Transportation – Base	5	0	(4,966)	104,604
CVR – Transportation – Vehicle	1	1	172,895	7,904
Diagnostic & Treatment Center	0	0	0	68,260
Fraud and Abuse	15	2	3,084,882	447,096
No Supervising Pharmacist	0	11	0	46,322
Nursing Home	0	0	0	136,500
Other	1	1	0	127,948
Personal Care	1	3	(510,309)	759,658
Pharmacy	0	12	(74,285)	(7,254)
Pharmacy Inspection Onsite	2	0	0	0
Provider Prescription Fraud	2	0	0	0
Service Not Rendered	0	0	0	37,432
Transportation	3	0	0	51
Unlicensed Provider	0	0	1,266,832	0
Total	67	58	\$ 3,936,265	\$ 2,075,687

SOURCE: New York Office of Medicaid Inspector General 2008 Annual Report, released October 2009

Undercover Investigations Unit, the Enrollment and Reinstatement Unit, the Provider Exclusions and Censures Unit, the Surveillance and Utilization Review System Unit, the Prescription Forgery Project, the Recipient Fraud Unit and the Recipient Restriction Program. Any patient could be an undercover investigator.

◆ *OMIG referred 88 cases to the New York state AG for potential prosecution as criminal cases; 72 were providers, while 16 were recipient cases.*

Sheehan's shop also recently posted details about its mandatory provider compliance-program certification efforts, too. For example, the certification form for Part 521 compliance regulations is now available online on the OMIG Web site. In fact, that's the only place it's available. Providers must certify their compliance programs on the Web, not on paper, reports Robert A. Hussar, OMIG's first deputy Medicaid inspector general, and OMIG must receive those forms by Dec. 1. "It's easier for providers, and it's certainly easier for us to log the certification forms in and then track them online," he tells *MCN*. "We haven't had any pushback from folks saying they couldn't do it online." There has been some response about the time frame, though, and the fact that certification lasts just a year. Still, Hussar notes that some providers have already started sending in their forms.

OMIG is drafting industry-specific guidelines that reflect the requirements of the mandatory compliance law and will make them available on its Web site, the site says. "OMIG does not anticipate issuing model compliance plans or templates," it says. But "providers are encouraged to monitor OMIG Corporate Integrity Agreements for compliance-related provisions." The mandatory compliance law provides that "a compliance program that is accepted by the U.S. Department of Health and Human Services Office of Inspector General and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provision of this law," the Frequently Asked Questions section of the Web site notes. But, it adds, "OIG does not review and 'accept' provider compliance plans."

Contact OMIG spokesperson Wanda A. Fischer at (518) 473-3782 or waf02@omig.state.ny.us. ✧

Self-Auditing Can Help Hospitals Prepare for Upcoming MIC Audits

With the imminent arrival of Medicaid Integrity Contractors (MICs), self-audits are more than a best practice for providers. They are a necessity. According to many health care attorneys and experts, providers must dedicate resources to those self-reviews now to prepare for inevitable federal audit activity.

"In light of the emerging onslaught of MIC audits, providers would be well-advised to step up their internal audits," says attorney Judy Waltz of Foley & Lardner LLP in San Francisco. "It's always better to identify your own problems, and fix them prospectively and make refunds if necessary, before the government finds them in an audit," she tells *MCN*.

Self-auditing allows providers to identify improper billing and other problem practices, and limit their losses, before those issues come to the attention of the government through a formal audit.

Moreover, "active and effective internal monitoring and auditing efforts are expected by the OIG [i.e., HHS Office of Inspector General] as part of an effective compliance program," says Waltz. Providers without effective compliance programs may be faced with allegations of "'reckless disregard' sufficient to meet the intent standard of the [federal] False Claims Act," she asserts.

That's especially true in light of recent amendments to the FCA under the Fraud Enforcement and Recovery Act of 2009, enacted in May. The amendments apply the FCA to situations where one "knowingly makes, uses or causes to be made, or used, a false record or statement material to a false or fraudulent claim, an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government."

Says Waltz: "It seems an easy step from that new provision for the government, or a whistleblower, to allege that a failure to conduct regular internal auditing demonstrates a reckless disregard for the integrity of claims submitted for payment."

Areas for Self-Audits Vary by State

Determining what areas to audit can be difficult and depends on the particular state Medicaid program, Waltz says. For example, hospital payments under one state program may be based on a traditional fee-for-service arrangement, reasonable costs, per-diem contract rates or DRGs, she explains. The potential audit issues will be different with each type of reimbursement.

States also vary in terms of the guidance they provide as to how to comply with Medicaid rules. Jim Hampton, administrator and fraud-and-abuse liaison officer for the deputy secretary for Medicaid of the Florida Agency for Health Care Administration, cautioned providers at a state-sponsored conference in September to perform self-audits that are "acceptable" to the state Medicaid program.

For example, says Waltz, in New York, the Office of Medicaid Inspector General has issued a Work Plan that is very specific as to the issues it will focus on, "provid-

ing something of a roadmap for providers." But other states, such as California, have not made specific compliance guidance readily available to hospitals and other providers, she says.

However, Waltz says that, given the fact that states will have to repay the federal government the federal share of identified Medicaid overpayments, it seems likely that more states will begin to proactively offer compliance guidance. Moreover, some issues identified as risk areas under Medicare by CMS as part of the recovery audit contractor (RAC) audits, or by OIG in its Work Plan and audits, will also be issues under some Medicaid audits, she asserts.

According to Jim Sheehan, New York Medicaid Inspector General, MICs will focus on the following issues:

- ◆ **Desk issues** — billing for dead patients, ambulatory services provided to inpatients and hysterectomies performed on male patients.
- ◆ **Field audit issues** — DRG assignments; observation beds; excisional debridement (requires actual cutting); heart and shock failure, to meet criteria for inpatient care and ambulatory surgery justifying an inpatient stay.
- ◆ **Failure to submit documents** in response to a MIC request.

In some states, Medicaid managed care plans are the primary payers, says Waltz. That may bring up "other audit implications." For example, acuity-based payments may lead a hospital to look at how it determines acuity and to confirm that it meets the standards required for acuity care, such as staffing ratios. Or, she notes, if a hospital's contract is based on per-diem payments, length-of-stay reviews will be critical.

Other areas Waltz suggests providers look at include medical necessity, accurate coding, complete documentation and quality-of-care issues. Waltz recommends to providers that they "focus on their quality indicators and quality compliance efforts." Also, providers should "remember that much of the Medicaid Integrity Program will be driven by data mining," she adds, "and [they should] consider what their footprint will be based on required information submitted to the state, which may help to focus audit priorities."

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Hospitals May Not Have Liability For Physicians' Compliance Woes

Hospitals' Medicaid compliance officers likely needn't panic if physicians who practice at their facilities get busted for fraud of their own. But they might want to dash off a quick "heads up" e-mail to their legal counsel, just to be safe. Institutional providers generally

do not have associated Medicaid compliance liability for the actions of staff or otherwise affiliated physicians, experts tell *MCN*, so long as none of the clear doctor-and-hospital violations are present. However, a state-by-state program like Medicaid holds many surprises for providers, so it behooves them to make sure they're up to speed on what their state requires when it comes to hospital responsibility for physician activity.

The issue has taken on new relevance in light of the recent "takedown of a major criminal narcotics network in Hudson County," as a statement from the New Jersey Attorney General (AG) puts it, "that was responsible for the black market distribution of thousands of prescription pain pills such as OxyContin and Percocet." Garden State AG Anne Milgram reported in mid-October the arrests of 13 people, including doctors and pharmacists, in "Operation MedScam," a year-long investigation by the Medicaid Fraud Control Unit of the Division of Criminal Justice's Office of Insurance Fraud Prosecutor and the Jersey City Police Department's Special Investigation Unit.

Two Doctors, Two Pharmacists Are Arrested

"The ongoing investigation uncovered a criminal network that was obtaining fraudulent narcotics prescriptions from doctors and filling them at various pharmacies," the AG's statement explains. "Medicaid and private insurers were being billed for phony prescriptions and doctor visits." Two rings, actually, were in operation, the AG adds, but they allegedly used the same pharmacists to obtain narcotics and at least one of the same doctors to write prescriptions. The alleged ring-leaders are accused of paying Medicaid beneficiaries to obtain fake prescriptions for painkillers and other drugs from two doctors — both of whom were arrested, as were two pharmacists. The other arrests involved "alleged street-level distributors for the narcotics rings."

The defendants are charged with a variety of offenses, including distribution of a controlled dangerous substance (CDS) within 500 feet of certain public property, distribution of a CDS, endangering the welfare of a child, distribution of a CDS within 1,000 feet of a school, conspiracy to distribute a CDS, possession of a CDS with intent to distribute, health care claims fraud and, of course, Medicaid fraud. The impact for hospitals lies in this statement from Acting Insurance Fraud Prosecutor Riza Dagli: "This type of health care fraud and street-level distribution doesn't occur without the involvement of the medical providers. Criminal activity by doctors, pharmacists and other professionals who are in a position of public trust is particularly egregious and is a priority for this office."

That's why at least one of the facilities where at least one of the accused doctors practices is taking a look at his

or her ability to do so. Several hospitals with ties to the arrested physicians refused to comment for this article, but Hoboken University Medical Center spokesperson Joan Quigley reports that her 328-bed facility's medical staff bylaws "are quite specific that any member charged with a felony has his/her admitting privileges suspended pending completion of an investigation."

Requirement May Depend on Circumstances

Such a focus on internal hospital-doctor issues is probably all that's required in such situations, compliance experts tell *MCN*. Don White, spokesperson for the HHS Office of Inspector General (OIG), does note that Medicaid can be a slippery beast when it comes to operational compliance rules because it's state-administered. There are, thus, potentially four dozen or so different sets of policies with which to comply. And even from the federal perspective, he says, "as the lawyers like to say, the answer often depends on the facts and circumstances."

However, he points out, the high-profile physician-hospital-related compliance bugaboos tend to involve situations where, for example, a physician has been excluded from participation in Medicaid and/or other federal health care programs but is nonetheless working for the hospital. In that case, the hospital could be liable for fines and penalties for having in its employ an excluded individual. Alternatively, the hospital could be liable if it's involved in a prohibited financial relationship with a particular physician — one involving kickbacks or paying for referrals or such things. And, depending on the specifics of the state, there could be quality-of-care liability involving some physicians.

However, that wouldn't seem to apply specifically to the challenging situation faced by the New Jersey hospitals in the wake of Operation MedScam. And there is, apparently, not a lot of risk of state-based hospital compliance liability for physicians' alleged misdeeds, either.

"Hospitals have considerable latitude in handling discipline on their medical staffs based on the procedures in their governing board and medical staff bylaws," notes Shawn Moore, a spokesperson for the Florida Agency for Health Care Administration. "From the state government's perspective, such cases would typically be handled exclusively through the practitioner's regulation process at the Board of Medicine or the Board of Osteopathic Medicine. The Agency would not typically become involved with the hospitals unless the specific situation led to a patient-care complaint that also involved a physician violating the law."

Otherwise, he points out, under Florida regulations anyway, "hospitals are not immediately implicat-

ed when members of their medical staffs are accused of illegal activity. It depends upon the details of each individual case." He does stress, though, that "if the Agency believed there was a possible systems failure in the hospital delivery of care that allowed any inappropriate action on the part of a hospital physician to go undetected, then an investigation would ensue."

And, Moore adds, "innocent until proven guilty aptly applies."

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Michigan Lawmakers Want An OMIG Just Like New York's

Michigan's Republican attorney general (AG), who's running for governor in next year's election, and two leading GOP lawmakers are proposing creation of an Office of Medicaid Inspector General (OMIG) in Lansing, a la Jim Sheehan's shop in Albany, N.Y. In an odd election-cycle twist, Democrats in the state say the new office is too costly and would simply duplicate the efforts of the state's existing Medicaid Fraud Control Unit (MFCU).

The legislation was introduced in the Senate as SB 942 by Sen. Roger Kahn and in the House as HB 5542 by Rep. Bob Genetski. The pair "worked closely with Michigan AG Mike Cox," a statement from Kahn's office says. One legislative staffer, in fact, tells *MCN* the bill "is his baby," and the lawmakers introduced it largely at his request.

Under the measure, a new inspector general's office would be empowered to oversee and audit Medicaid system contracts, perform on-site inspections and audits of facilities where the records of Medicaid recipients are kept, accept and investigate complaints from the public, subpoena and enforce the participation of witnesses, and refer criminal and civil cases to the AG. It would operate independently from the Michigan Department of Community Health, and its leader would be appointed directly by the governor "to ensure autonomy from state Medicaid program administrators," the statement says. Because the new office would be crafted by reconfiguring the current MFCU, the sponsors say, "no new funds are necessary to create it."

The House in Michigan is now under Democratic control, as a result of the 2008 elections. Local news reports of the press conference where the bill's introduction was announced quote the state's Democratic Party leader, Mark Brewer, as saying that the AG has prevented only \$20 million in fraud and alleged that his office has failed to recover \$1 billion a year. The

problem, the Democrats say, is a GOP AG who's more concerned with his campaign for governor than with prosecuting Medicaid fraud. There would be no need for an OMIG, the opposition says, if the MFCU were working like it's supposed to. Gov. Jennifer Granholm (D) also worries about auditors' unrestricted access to patient documents.

Texas, Illinois, Florida, Kansas and New Jersey also have independent Medicaid inspectors general.

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CMS's Medicaid Scrutiny Toughens

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As a result, he added, "we have encouraged our contractors to first do a probe sample of up to a couple hundred medical records to determine if the results we expect from the algorithm can be found in the probe sample. If not, there may be something we missed, or the algorithm didn't work as expected." He emphasized that CMS has guidelines for MICs to ensure quality and accuracy in their work, and that CMS monitors the contractors.

The majority of MIC audits are desk audits, which means the auditors don't make site visits, Miller said. Auditors request medical records from providers and conduct audits at their own offices. "The contractors go back and forth with providers," he explained.

However, some audits are field audits, but providers are warned in advance about those. Auditors "don't show up unannounced," Miller told listeners. The main reason: CMS wants providers to have time to prepare medical records for the on-site audits. Providers may be able to avoid copying the documents altogether for on-site audits, and instead just set them out on a table. "We can copy the ones that are relevant," Miller added.

CMS has not dictated a deadline by which providers must produce medical records requested by MICs. Medicare recovery audit contractors (RACs) give providers 45 calendar days plus 10 days for mailing snags, and "we are moving toward that," Miller said. But for now, "we tell contractors to generally follow the lead of the state in which they are operating," but also to work with providers. "We are not trying to create inappropriate additional burdens," he emphasized. "We understand there will be additional burdens — there is no getting around that — but we don't want to create false deadlines."

Meanwhile, 3,800 program integrity officials from the 50 states, the District of Columbia and five U.S. territories are attacking Medicaid fraud, waste and abuse, Miller said. About one-third received specialized training at the

Medicaid Integrity Institute, which is located at the National Advocacy Center run by the Department of Justice and National District Attorneys Assn. The program integrity officials are learning more about data mining and CPT coding, among other things, Miller reported during the audioconference. That training also fosters the identification of "multistate regional [audit/investigative] projects that we are in the process of developing," he said.

Consistent with its use of the enrollment process as a program-integrity tool, CMS for the first time has initiated the "Unified Provider Enrollment Project," Miller said. CMS is creating a single national portal that vets providers for Medicare before they are allowed to participate in any state Medicaid program.

It won't be easy to get in Medicare, he stressed. "We will run a broad series of verifications," such as licensure and the Medicare exclusion database, and possibly check for criminal backgrounds, he explained. Also, CMS will conduct background checks on directors and people with 5% or more of an ownership stake in a provider entity.

"By unifying the provider enrollment process on the front end, we will keep out providers who should never have been let in" to Medicaid and Medicare, he said. And it makes the Medicaid enrollment process consistent, because now state screening is all over the map. For example, "all states check the legal name [of the provider] for exclusions," he noted, "but relatively few states check exclusions on an ongoing basis."

Audits Are Seen as Becoming High-Powered

Former Texas Medicaid Inspector General Brian Flood says Miller's statements show there's a "sea change" in Medicaid enforcement. The use of "seasoned investigators," contractors, data mining and a university supercomputer to crunch the numbers is evidence of how high-powered audits and investigations have become, he comments.

Providers should be warned that when auditors appear at the door, "they have already identified you as a problem," says Flood, who is now a managing director with consulting firm KPMG in Austin, Texas. "That's much different than being randomly selected for an audit. It gives a different flavor to a meeting if the other side already believes you violated policy or law. If it's a random audit, then [the Medicaid auditors'] opinion of you is neutral." On the other hand, he notes, if auditors go in with a computer printout that says your billing utilization is way outside the norm, "that has a tendency to skew the review from the beginning."

View the Medicaid Integrity Program Web site at www.cms.hhs.gov/MedicaidIntegrityProgram. E-mail the Medicaid Integrity Group at Medicaid_Integrity_Group@cms.hhs.gov. ♦

NEWS BRIEFS

◆ **The CMS Web site, www.cms.hhs.gov, now includes National State-by-State Medicaid Statistical Information System (MSIS) Medicaid eligibility and claims tables for federal fiscal years 2005 through 2008 for 31 states.** The tables contain “pre-defined, high-level, aggregated state-level data,” a statement says, and each table detail page contains a link to the MSIS data marts, allowing users to “perform additional analysis of the summary-level information.” The table detail pages also contain links to the listings of state data-reporting anomalies and issues that should be considered when reviewing the data, CMS points out. The tables will be updated periodically, the feds say, as more states submit their data for the full fiscal years reviewed and as those data are approved through the federal government’s “standard quality reviews.” Also, the MSIS data marts will be updated with states’ full sets of summary-level information as approved. The document with tables for fiscal years 1999 through 2004 is still available on the CMS Web site, too.

◆ **A suspect accused of Medicaid fraud in Washington state has been arrested in Madagascar and returned to U.S. custody,** the U.S. Attorney’s Office (USAO) in Seattle says. Law enforcement officers on the African island nation learned that Antoine Johnson’s passport had expired and that American authorities had issued a warrant for his arrest. After spending a short time in local custody in Madagascar pending deportation proceedings, he agreed to return to the U.S. voluntarily. Johnson stands accused of Medicaid fraud for “billing the state for medical services not provided” in at least one of the four clinics he operated. Authorities raided the clinics after auditors from the state Department of Social and Health Services noticed Medicaid billing irregularities at one of them. That’s when Johnson allegedly fled. Also, a USAO statement says, officers with the Grays Harbor County Drug Task Force “came to believe prescriptions for narcotics were being issued from the clinics for cash payment.” Undercover agents visited the clinics on multiple occasions posing as patients. Conspiracy to commit health care fraud is punishable by up to five years in prison and three years of supervised release. Johnson’s attorney did not return calls requesting comment. Contact the USAO at (206) 553-4110.

◆ **Douglas P. Dvorak was sentenced in October to more than seven years in federal prison for filing false Medicaid claims using the stolen identities of minors,** according to the USAO in Cedar Rapids, Iowa. A jury found the chiropractor guilty of 22 counts of mail fraud, 11 counts of aggravated identity theft and six counts of money laundering. “The evidence at trial showed that, between late 2005 and early 2007, Dvorak used the identities of more than 30 under-aged Medicaid beneficiaries in executing the scheme to defraud,” a USAO statement says. He also “engaged in financial transactions with the proceeds of his fraud that were designed to conceal the location and control of the proceeds,” the USAO adds. Evidence presented at the sentencing hearing established that he intended to defraud Medicaid out of more than \$120,000. Of the 85-month sentence, 37 months were imposed for the mail-fraud and money-laundering convictions and 48 months were imposed for the aggravated identity-theft convictions. A special assessment of \$3,900 was imposed, and the defendant was ordered to make \$71,375.82 in restitution to Iowa Medicaid Enterprise. He must also serve a three-year term of supervised release after the prison term. There is no parole in the federal system. Contact the USAO in northern Iowa at (319) 363-0091.

◆ **Los Angeles-based Darryl Clarence Harris, M.D., pleaded guilty to health care fraud in the Eastern District of Texas, where he used to practice,** according to a statement from the Lone Star State’s attorney general (AG). According to information presented in court, Harris, an obstetrician/gynecologist, “commonly submitted claims for ultrasounds and microbial identification tests, but as he was aware, his office was not capable of performing the tests.” At the end of February 2005, two physicians practicing with Harris left the practice and took the ultrasound and microbial testing equipment with them. So from March 2005 until August 2005, Harris did not have access to ultrasound equipment, and from March 2005 until November 2005, he did not have access to microbial testing equipment. But he continued to bill Medicaid for both tests and submitted claims for hundreds of unperformed tests, resulting in the fraudulent payment of \$76,683 from the Texas Medicaid program. Harris faces up to 10 years in federal prison at sentencing. Contact the Texas AG at (512) 463-2050.

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