

## HEALTH CARE OFFICIALS WILL CONTINUE INTENSE FOCUS ON FRAUD

by

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The Federal government's commitment to ensure proper claims practices under Federal health programs and to detect and prevent fraud and abuse is not expected to wane under the Bush Administration or with the current Congress. Funding is politically committed through 2004 to ensure proper Medicare and Medicaid program administration and efforts to combat fraudulent and abusive practices. Furthermore, the efforts of the Health Care Financing Administration ("HCFA"), the Office of Inspector General of the Department of Health and Human Services ("OIG-HHS") and the Department of Justice ("DOJ") over the past several years has resulted in significant monetary recoveries which has reinforced the continued fiscal and political viability of program integrity and enforcement efforts against fraud and abuse in Federal health programs. This commitment is reflected in the current plans of HCFA, the OIG-HHS, and the DOJ to move forward in this effort during the Bush Administration. This LEGAL BACKGROUNDER will review in a summary fashion the scope of foreseeable enforcement plans for each of these agencies and the specific practices and targeted areas under each of the agencies' areas of jurisdiction.

**Health Care Financing Administration.** HCFA is committed to a more patient- and provider-friendly orientation and administration of the Medicare and Medicaid programs. Nevertheless, this will not mean abandonment of their historical role in ensuring the appropriateness of claims and reimbursement and eligibility for coverage and payment under the Medicare and Medicaid programs. This perspective and HCFA's commitment to program administration are reflected in its recently implemented initiative, the "Medical Review Progressive Corrective Action." The "Progressive Corrective Action" initiative is laid out in a HCFA Program Memorandum ("Program Memorandum") to all fiscal intermediaries and carriers issued late last year and implemented during the early months of the Bush Administration. Program Memorandum/Intermediaries and Carriers, Health Care Financing Administration, Department of Health and Human Services, Transmittal AB-00-72, August 7, 2000.

The Program Memorandum includes instructions and further guidance on underlying principles and procedures to be used by fiscal intermediaries and carriers in deciding how to deploy its resources and to undertake medical review. The concepts reflected in the Program Memorandum already appear in existing manual instructions, but are amplified and highlighted in the Program Memorandum for easier understanding and identification of HCFA's basic expectations regarding Medicare program administration by fiscal intermediaries and carriers. The Program Memorandum clearly calls for the contractors to be more provider-

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friendly and to engage in “educational,” as opposed to punitive and sanction-oriented activities, (i.e., overpayment, suspensions and/or exclusion actions, or referral to the OIG or DOJ). By no means, however, does it abandon the need to ensure appropriate billing and claims procedures and the referral of matters to the OIG or DOJ where fraudulent and abusive practices are detected.

The Program Memorandum points out that the decision to conduct medical review should be primarily data-driven to determine whether patterns of claims submission and payment indicate potential problems for particular providers and suppliers of health care services. Such data analysis may include simple identification of aberrations in billing patterns within a homogeneous group (“peer group”) or much more sophisticated detection of patterns of claims or groups of claims that might suggest improper billing or payment. The Memorandum states that data analysis itself may be undertaken as part of general surveillance, and a review of claims may be conducted in response to information about specific problems stemming from complaints, provider/beneficiary input, and fraud alerts, or government reports by HCFA or other contractors or agencies. This is a reiteration of the commitment which we have seen during the Clinton Administration, but it is tempered somewhat by the instruction to offset any overpayment determinations by any underpayments which are identified in a sample of claims. It is also modified by instructing fiscal intermediaries and carriers to take into account repeated reversals of fiscal intermediary and carrier claims decisions once they have been appealed by providers and suppliers to higher levels in the administrative review process. This is certain to have a mitigating impact on fiscal intermediary and carrier practices since many of their decisions have been successfully challenged in the recent past.

The Program Memorandum also instructs fiscal intermediaries and carriers to validate potential problems by conducting “probe” sample reviews — usually, a review of 20-40 claims to effectively identify whether or not a problem exists. The Program Memorandum, however, additionally instructs contractors to notify providers and suppliers when they are made subject to a “probe” of a sample of claims and to limit the scope of the probe to only those areas necessary to address the nature and extent of the particular identified problem. This should alleviate a common provider and supplier fear that a medical review action will expand to areas beyond the originally identified problem.

The Program Memorandum further emphasizes the need to engage in feedback to providers and suppliers in the form of education and identifies this as an essential part of resolving claims and payment problems identified by the contractors. Such a policy could have the beneficial effect of weeding out situations which arise merely because of mistakes, before they become the subject of more severe administrative sanctions or referrals to OIG or DOJ as a fraud and abuse matter. The fiscal intermediaries and carriers, however, are still expected to employ comprehensive medical review, pre- and post-payment reviews, and pursuit of overpayment actions where the steps outlined in the Program Memorandum identify continuing provider and supplier problems. In fact, the Program Memorandum clearly instructs contractors to employ suspension of payments and referral of cases to the OIG-HHS for exclusion or civil money penalty action or referral to the DOJ for criminal and civil enforcement action, when appropriate.

The specific focus areas HCFA has identified for 2001 are as follows:

- upgrading its resources and technical and management skills to detect and combat inappropriate billing and claims procedures and fraud and abuse;
- continuing focus on laboratory billing and in particular, billing inefficiency by laboratories and failure of laboratory claims to be supported by medical necessity;
- maintaining a continuing effort by fiscal intermediaries and carriers to monitor providers and suppliers that have previously been the subject of serious fraud and abuse investigations and/or settlements of criminal and civil enforcement actions; and
- maintaining a commitment for onsite review by HCFA representatives of fiscal intermediaries and carriers to ensure fulfillment of their obligations, including the specific requirements of the Program Memorandum.

**Office of Inspector General.** OIG-HHS increased staffing and resources significantly during the latter years of the Clinton Administration. The impact of this increase has not yet been completely realized. It is expected that the number, scope, and intensity of enforcement actions resulting from these expanded resources will continue to be seen during the Bush Administration. There has been a steady increase in exclusion actions by OIG-HHS and it is expected that there will be more discretionary (i.e., “permissive”) exclusion actions undertaken for the next several years. OIG-HHS has also begun to utilize its newly expanded authority to impose civil money penalties in false claims cases and recently, in cases involving violations of the Federal Anti-Kickback statute (“Anti-Kickback Statute”) when the DOJ declines to take enforcement action under the criminal authority under that law. The OIG-HHS is also expected to continue its expanded efforts in ensuring compliance with the health care fraud and abuse laws by the implementation of corporate integrity agreements (“CIAs”) and the monitoring of already existing CIAs for effectiveness in achieving the objectives outlined in those agreements. There will also be continued activity involving the publication of Advisory Opinions with its corresponding sentinel effect on compliance with the prohibitions under the Anti-Kickback Statute and the statutorily enumerated basis for program exclusion.

The areas of focus which have been specifically identified by the OIG-HHS during the upcoming year include the following:

**Hospitals.** The OIG-HHS intends to continue focus on satellite hospitals, prospective payment system (“PPS”) transfers, the DRG payment limits, and outlier payments for expanded services. The OIG-HHS is also expected to focus on the implementation of outpatient reimbursement under PPS, outpatient medical supplies at acute care hospitals, and outpatient pharmacy services at acute care hospitals.

**Home Health and Hospice Care.** The OIG-HHS will continue to focus in the home health arena with a particular emphasis on ensuring the implementation and effectiveness of home health compliance programs. There will also be a focus on physicians involved in approving home health care and the plans of care for home health patients. The agency is further expected to focus on hospice payments to nursing homes and the use of continuous home care by hospice agencies.

**Nursing Home Care.** The OIG-HHS will also focus on the role of the medical director in nursing home care, develop information related to family experience with nursing home care and review implementation of the consolidated billing requirements and PPS for nursing home services. It is also expected to focus on ineligible stays in skilled nursing facilities and follow-up mental health services in nursing facilities. There is also expected to be a focus on the provision of therapy services for Medicare Part B nursing home patients and ancillary medical supplies for these patients. The continued survey and review process of nursing homes is also expected to continue the escalation of cases involving the imposition of civil money penalties for deficiencies in nursing home conditions of participation.

**Physicians.** The OIG-HHS is expected to complete its investigation and enforcement actions involving Physicians at Teaching Hospitals (“PATH”). There will also be a continued focus on billing for podiatry services, the use of critical care codes, the use of services and supplies in incident-to-physician services and the continued focus on the role of non-physician practitioners, such as nurse assistants, physician assistants, and other ancillary personnel.

**Medical Equipment and Supplies.** This will continue to be a focus, as it has been in past years, with existing and expanded scrutiny of payments for equipment and supplies.

**End-Stage Renal Disease.** This has been a growing area of focus for HCFA, the OIG-HHS and DOJ, particularly with respect to laboratory billings for ESRD patients, Medicare payments for ancillary drugs, such as Epogen, and duplicate payments for office visits to nephrologists for patients treated in a ESRD facility.

**Pharmaceutical Reimbursement.** The OIG-HHS will continue to focus on the effect of average wholesale price discounts on Medicare prescription drugs and payment for Medicare outpatient drugs.

**Managed Care.** The OIG-HHS is expected to continue its focus on enrollment incentives and disincentives for managed care organizations, physician incentive plans involving withholding of medically necessary services, enhanced managed care payments, prescription drug benefits under managed care plans, review of marketing materials, and monitoring Medicare + Choice managed care plans and their required compliance programs.

The OIG-HHS is also likely to enhance its review of Medicare fiscal intermediary and carrier operations. This is expected to involve comparison of payments and program integrity safeguard activities, critical review and follow-up on fiscal intermediary and carrier fraud control units, review of controls over exorbitant payments by contractors, payments for durable medical equipment, the imposition of suspension of payments to providers and the use of recovery firms and provider education and training. This is expected to have a significant effect on the degree to which contractors initiate the medical review process and referral of matters for OIG-HHS or DOJ action. *See, e.g.,* Department of Health and Human Services, Office of Inspector General Work Plan, 2001.

**Department of Justice.** The DOJ has also staffed up during the past eight years to target health care fraud and abuse. This has taken the form of recruitment and training of singularly dedicated criminal and civil attorneys responsible for enforcement of health care fraud matters. This has also involved the recruitment and training of investigators and auditors directly assigned to main DOJ and the United States Attorney's Office. This effort has also been supplemented by the expanding role of the Federal Bureau of Investigation ("FBI") in the investigation and enforcement of health care fraud and abuse matters. This expansion of resources and commitment at the DOJ has not yet been completely felt in the industry and is expected to continue to be a driving force in the Bush Administration.

The DOJ's efforts in the enforcement of health care fraud matters is expected to continue to be driven, to a great degree, by the proliferation of "whistleblower" suits under the United States False Claims Act ("FCA"). These actions not only generate a civil fraud case in a direct way, but also provide information to the DOJ which may form the basis of an independent and/or parallel criminal enforcement action. The commitment to enforcement in this area is not expected to wane during the Bush Administration, although the selection of which whistleblower cases to take over and intervene in is expected to become more sophisticated and resources could be applied in a more direct way to major types of systemic fraud actions.

The DOJ is expected to continue and complete major fraud investigation initiatives which were begun during the Clinton years (billing for investigational devices, PATH actions, recoveries, and hospital-physician relationships), as well as continuing its large-scale enforcement actions against major providers and suppliers, such as Columbia HCA, targets in the end-stage renal disease (ESRD) industry, the nursing home arena, and the pharmaceutical industry. The DOJ is also likely to continue its recent vigorous enforcement under the Federal Anti-Kickback statute where successful prosecutions in this area of the law are expected to be reflected in numerous other cases and jurisdictions throughout the nation. The continued proliferation of whistleblower cases plus the initiatives previously discussed by HCFA and the OIG-HHS will continue to fuel and provide numerous cases which the DOJ can pursue, both civilly and criminally, under its own authority.

**Conclusion.** There may be a slight change in emphasis on the scope and targets of health care fraud enforcement efforts under the Bush Administration, but for the most part, the effort initiated during the Clinton years is expected to continue. It remains to be seen if there will be a commitment to additional funding and resources for the health care fraud enforcement effort, but existing resources already reflect a dramatic increase over past years with the full impact yet to be completely felt in the nature and scope of the actions taken by the Federal government.