

Legal Issues

By Janet K. Feldkamp, JD, RN, LNHA

February was a busy month for mugshot photographers and health professionals posing for them. The number of providers and the amounts of money involved in charges of Medicare and Medicaid fraud were staggering.

On Feb. 3, the Health and Human Services Office of Inspector General issued

its first "Top 10 Most Wanted" fugitives in health care. Among them was Susan Bendigo, accused of collecting \$10 million from California's Medicaid program for the services of licensed home-health nurses while she actually used unlicensed nurses for the work.

On Feb. 15, the Department of Justice

charged 20 individuals, including three doctors, with billing Medicare \$200 million for mental health services that were medically unnecessary or not provided. Various defendants allegedly paid owners and operators of halfway houses and assisted living facilities to deliver Medicare patients to mental health cen-

ters, including dementia patients who couldn't benefit from the services there.

On Feb. 17, the Department of Justice announced that its Medicare Fraud Strike Force had charged 111 defendants in nine cities, "including doctors, nurses, health care company owners and executives," with \$225 million worth of Medicare fraud. The government alleged that the defendants paid patient recruiters and even patients themselves to reveal beneficiary information so that the providers could submit claims to Medicare for services that were either never provided or medically unnecessary.

Before any of the cases above occurred, an Obama administration report said that its health-fraud prevention

and enforcement efforts had recovered more than \$4 billion in fiscal year 2010. In addition, the Department of Justice recovered more than \$2.5 billion under the False Claims Act.

Curbing Medicare and Medicaid fraud was one of the fiscal pillars of last year's Affordable Care Act. Savings there are being counted on to fund health reforms that will cost extra federal dollars. Now, as many states face budget deficits, they too are looking for ways to save on Medicaid, and attacking fraud in that program is becoming a priority at that level of government.

Fraud is not only billing for services that were not rendered, but also billing erroneously, even when the "intent" was not fraudulent. Recently, the St. Joseph's/Candler Health System in Savannah, Ga., agreed to pay the state more than \$2.7 million to settle an investigation into the system's "crossover" claims for patients who are beneficiaries of both Medicare and Medicaid.

For these dually eligible patients, Medicare is the primary insurer and Medicaid the secondary payer. The investigation into the hospital system's billing practices found that it filed Medicaid claims that did not reflect entire amounts the system had received from Medicare, which yielded excessive Medicaid payments.

In announcing the settlement, Georgia's Attorney General Samuel S. Olens said, "All instances of overbilling as well as fraudulent billing in the state Medicaid system will be vigorously investigated by my office."

Another fraud trap to avoid involves nursing home staff and physicians who have been excluded from participation in Medicare or Medicaid.

The Federal Civil Monetary Penalties
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Ms. Feldkamp

Administration Touts Crackdowns on Health Fraud

WASHINGTON – The new Center for Program Integrity and the Medicare Fraud Strike Force are among federal efforts aimed at combating fraud and abuse in the Medicare and Medicaid programs, top federal officers testified at a hearing of the Oversight Subcommittee of the House Ways and Means Committee.

Subcommittee Chair Charles W. Boustany (R-La.) called the hearing because “without action, the problem is only going to get worse. Every dollar lost to

health care fraud is a dollar not spent on patient care.”

The Center for Program Integrity (CPI) was created by the Affordable Care Act and is now in the Centers for Medicare & Medicaid Services. Among CPI’s first tasks is to implement risk-based screening for new Medicare- and Medicaid-participating providers, according to Peter Budetti, the director of CPI.

The new rule holds providers and suppliers to a higher degree of scrutiny ac-

ording to their levels of past interactions with CMS and law enforcement agencies, Mr. Budetti said.

Lewis Morris, chief counsel to the Office of Inspector General of the Department of Health and Human Services, told how the Medicare strike force has brought charges against more than 1,000 defendants, recovering nearly \$2.3 billion since its inception in 2009.

The subcommittee also heard from Aghaebuna “Ike” Odelugo, who pled

guilty in August 2010 to fraudulently billing Medicare for close to \$10 million. “This system has a number of weaknesses which are easily exploitable,” Mr. Odelugo said, adding that all he needed was a basic knowledge of data entry and people to recruit patients and falsify claims.

According to Mr. Morris, money spent on pursuing fraudsters yields a \$6.80 return on the dollar.

—Frances Correa

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Law imposes fines on a provider who employs or contracts with an individual or entity the provider knew, or had reason to know, was excluded from federal health care programs. Penalties are up to \$10,000 for each claim plus up to three times the amount that was paid or claimed.

While many nursing homes, hospitals, and group practices verify that a potential employee is not on the federal list of excluded individuals, they do not necessarily have ongoing procedures for making sure employed or contracted individuals have not fallen onto the list. The exclusion list is available online from the HHS Office of Inspector General at http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

Health care providers should also regularly ensure that none of their employees or contractors has been excluded from participation in federal contracts. This list is published by the U.S. General Services Administration at www.epls.gov. Many individual states also publish their own exclusion lists.

As both federal and state governments increase their antifraud efforts as a cost-containment strategy, health care providers must ensure that their Medicare and Medicaid claims are completed properly, even if they would never entertain the faintest hint of fraudulent intent. Even “careful” health care providers should review their relationships with others and their procedures and practices to ensure that they are in compliance with the law.

Providers from individual physicians to large health care companies should revisit their internal plans for ongoing compliance, including the prompt investigation of concerns that might be brought forward by an employee, a contractor, or anyone else who might have seen a breach in compliance with any of the many laws and regulations that govern health care.

This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.



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