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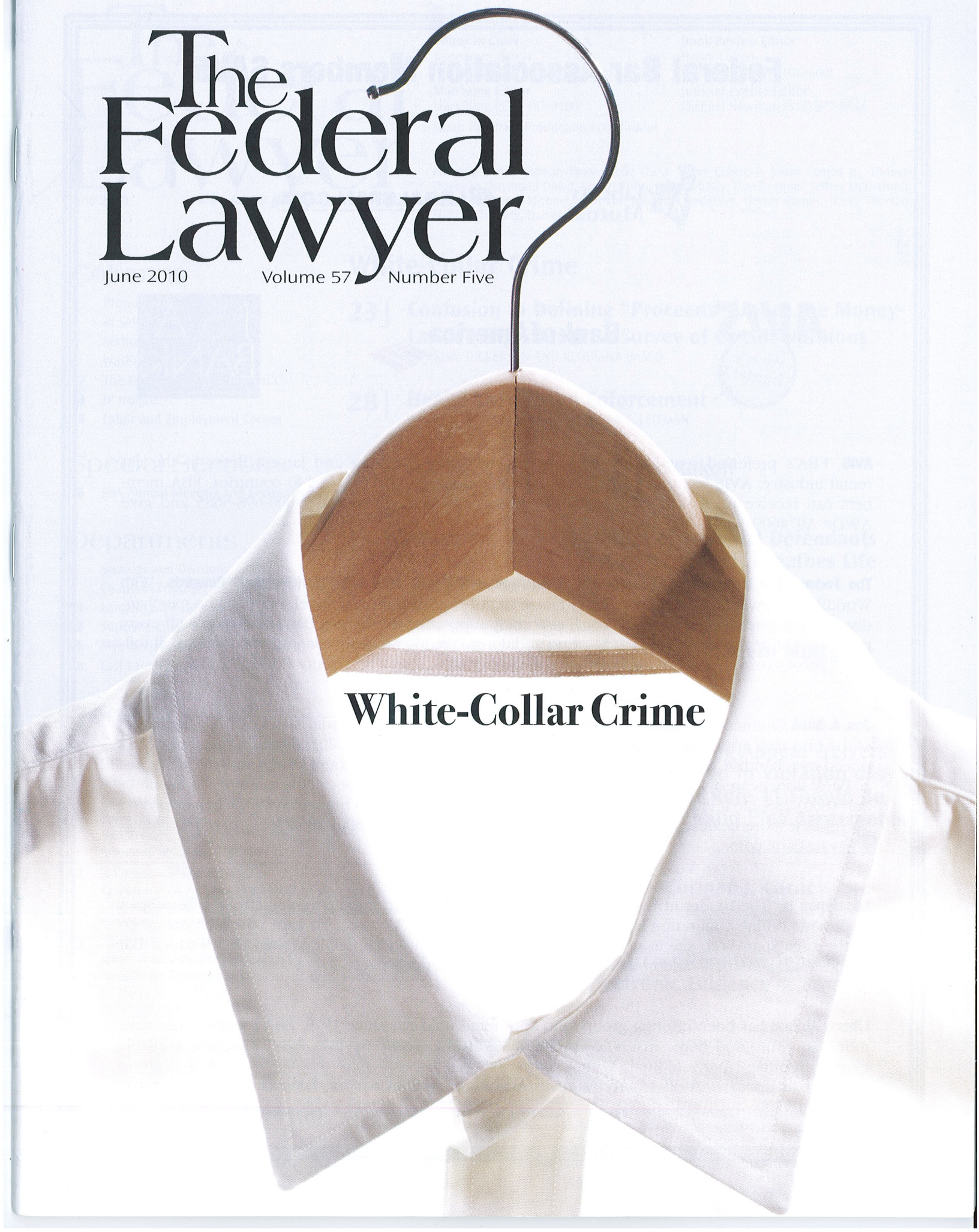


White-Collar Crime

By Pamela C. Enslen and Matthew F. Leitman

Despite modest coverage by the media, a key element of this spring's landmark health care reform legislation was increased support for cracking down on health care fraud. The Patient Protection and Affordable Care Act includes an additional $250 million in funding over the next decade to curb health care fraud, waste, and abuse; according to the Congressional Budget Office, this feature of the bill will reduce the federal deficit by $138 billion over the next decade and another $1.2 trillion during the decade after that. It is not surprising, then, that this aspect of the bill was probably one of the least controversial, given the astounding costs attributed to health care fraud.

In January 2010, Attorney General Eric Holder issued a statement that health care fraud produces costs amounting to 33 times the box office gross of "Avatar," the highest earning movie of all time. The dollar amount of Holder's estimate was $60 billion in public and private spending for health care. In March, President Obama told a Missouri audience that nearly $100 billion in taxpayer revenue was lost in 2009 because of improper payments, mostly through Medicare and Medicaid distributions; the President stated that, if there were a "Department of Improper Payments," it would be one of the largest government departments.

Everyone agrees that health care fraud, waste, and abuse must be reduced, and this is one reason why the President's plan to enlist the help of high-tech private auditors, whom many have dubbed "bounty hunters," was met with rare bipartisan support toward the end of the debate on health care reform. Whereas taxpayers and politicians will be happy about the crackdown success stories of these modern-day bounty hunters, lawyers and judges should anticipate handling a growing caseload and docket centered on issues involving health care fraud.

This article begins by examining the growing emphasis on and resources devoted to curbing health care fraud, then discusses the types of fraud investigated and the nature of the investigations themselves. We highlight a number of "red flags" that investigators look for and suggest strategies to help medical practitioners avoid triggering these red flags. The article concludes with an overview and guidance for counseling clients in this growing area of health care and criminal law.

Health Care Fraud Prevention and Enforcement Action Team and Medicare Fraud Strike Forces

In spring 2009, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), was formed by the Department of Justice (DOJ) and the Department of Health and Human Services (DHHS) in order to bring senior leaders from both departments together for the purpose of building upon existing programs to strengthen the government's effort to combat health care fraud. The Medicare Fraud Strike Forces, operating throughout the country, are one of the existing programs greatly expanded by the new resources invested by HEAT. The Strike Forces are interagency teams made up of federal prosecutors and federal, state, and local investigators who work together to combat Medicare fraud, abuse, and waste. The first Strike Force was established in March 2007 in Miami, Fla; since then, Strike Forces have found homes in Los Angeles, Houston, Detroit, Brooklyn, Tampa, and Baton Rouge—all areas known for their prevalence of widespread health care fraud or suspected of being areas where such fraud is prevalent.

The Strike Forces have been extremely successful at identifying and investigating suspected offenders, resulting in cases against hundreds of individuals and leading to the recovery of more than $265 million in court-ordered restitution since 2007. In addition to reducing improper payments, the Strike Forces aim to raise public awareness about health care fraud and to increase community policing. Having a local presence in the nation's "hot spots" for health care fraud has certainly helped these teams in this effort.

The Strike Forces are also credited with helping the DOJ reach record levels of achievement in the fight against health care fraud. In 2009, the DOJ brought charges against more than 800 individuals for health care fraud offenses—an all-time high—and obtained more than 580 convictions. On the civil side, in 2009, more than $2.2 billion in judgments for those accused of health care fraud were recovered under the Federal False Claims Act.

State Medicaid Crackdowns Follow Suit

At the state level, in recent years, several programs have been unveiled aimed at similarly cracking down on Medicaid fraud and other health care fraud. In New York, where an independent auditor's office uses information technology resources to data-mine and investigate suspicious claims, $551 million in improperly paid Medicaid funds were recov-

ered in 2008. Unlike most states' Medicaid fraud and control units, which are housed in the attorney generals' offices and barred by law from searching individuals' records, the Office of the Medicaid Inspector General in New York is able to use advanced data-mining techniques to turn up suspicious activity. Similar independent auditors' offices have been set up in Florida, Texas, Illinois, Kansas, and New Jersey; other states, like Michigan, are actively exploring the option as a popular campaign promise for the 2010 elections.

Types of Fraud

The Medicare Fraud Strike Forces and other health care fraud investigators are trained to look for certain kinds of patterns and inconsistencies in the paperwork and practices they investigate. Some of the schemes these teams typically look for include obviously false statements on Medicare forms, kickbacks in exchange for Medicare referrals, and physicians' "self-referrals."

Another major area of focus is billing fraud, which could include any of the following:

- billing phantom patients or patients who are deceased;
- billing for services never provided;
- billing for old services as if they were new;
- billing for extra hours or unnecessary tests;
- billing for equipment that is medically unnecessary, whether or not it is provided;
- billing for personal expenses;
- overbilling or double-billing for services; or
- upcoding or unbundling of services.

Billing fraud can appear in any of the health care subsectors and is not just limited to Medicare cases. A year ago, a large managed care company in Florida, WellCare Health Plans, was forced to pay $80 million to settle claims that it had defrauded the Medicaid system. The company was accused of systematically and fraudulently inflating information about expenditures for three and a half years in the mid-2000s.

One area targeted as a hotbed of fraud involving fraud in billing for health care delivery services is the durable medical equipment industry. These companies sell equipment, like motorized wheelchairs and in-home hospital beds, and supplies, such as arthritis kits. Last November, an individual in Texas pleaded guilty to submitting $962,000 in false Medicare claims for items like nutritional products and heating pads; in February, another Texas man was convicted of defrauding Medicaid of more than $1.1 million by billing the state of Texas for adult diapers (extra large ones, which have the highest Medicaid reimbursement rate), underpads, and wipes in massive quantities over and above what the patients needed.

Another industry of interest for investigators is home health care because of the perceived low transparency and accountability associated with providing services. Since the care that is provided, which is charged to federal programs, takes place in patients' homes and not in any one central facility, it can be harder for investigators to verify facts and easier for schemers to get away with fraud. In Miami, investigators went door-to-door to supposed Medicare recipients' houses and discovered that one home health care agency was billing Medicare for insulin shots for patients who did not have diabetes.

Another popular scheme is to bill Medicare for home health care services that are provided elsewhere or are not provided at all. For instance, because there is a cap on how much can be billed for physical therapy done at physicians' offices, some schemers have been billing physical therapy as home health care service. This was the case in Detroit, where the owner of a home health care agency recently pleaded guilty to organizing a $10.9 million scheme that included paying kickbacks to physicians for fraudulent referrals and billing Medicare for physical therapy done at patients' homes and for other treatments that, in fact, were never provided.

Investigations and Audits

To sort through the volumes of claims, investigators use a variety of tools, including the latest computer technology, for data-mining and quantitative analysis. The data-driven approach, using high-tech computers to zone in on complex but unjustifiable billing patterns, is credited as a cornerstone of the successes achieved by the Strike Forces. Investigators often examine Medicare billing records in six-month increments in order to identify significant changes in billing patterns, such as inconsistent treatments or frequent changes in address. Given the increased financial risk to federal programs, high-volume and high-cost procedures are more likely to be investigated. In addition to their complicated computer algorithms, investigators also rely on anonymous tips and informants' accounts. In some cases, Medicare beneficiaries may also be interviewed to determine whether the care they received was legitimate and whether it matches the billing record.

Under the program promoted by President Obama during the final weeks of the debate on health care reform, independent auditors or bounty hunters will use advanced computer programs as well as their forensic accounting expertise to troll through billing records looking for fraudulent claims. These "payment recapture audits" will be done on a contingency basis, whereby the auditors receive a small fraction of the recovery, with the majority of the recovery going to pay for the costs of the audits and back to other government agencies. This newest measure in the crackdown on health care fraud is expected to increase the number of red flags raised and investigated, subsequently resulting in higher recovery rates and also in more criminal prosecutions.

Red Flags

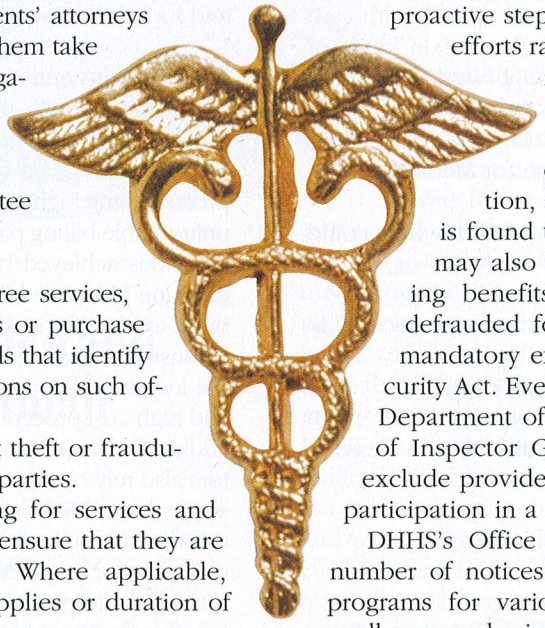
At both the federal and state levels, investigators are looking for certain suspicious red flags in corporate billing and paperwork that could suggest fraudulent activity. The following list is a small sampling of practices that may raise a red flag, which could trigger an investigation:

- a single diagnosis for all patients,
- the same treatments for all patients,
- rare and expensive treatments or services,
- lack of follow-up care,
- geographic disparity among patients,
- inconsistent diagnoses for the same patient,
- a doctor who treats too many patients,
- a patient who sees too many doctors,

- a patient being prescribed too much or widely varying equipment,
- a patient being treated at home for treatment typically done in a medical facility or clinic, and
- a patient who goes to specialists for standard treatment normally available from a primary care physician.

Advising Health Care Clients

Given the intense efforts to crack down on health care fraud, honest health care practitioners may someday find themselves the subject of an investigation if a red flag is falsely raised. The best thing such clients' attorneys can do is to be prepared and to help them take proactive steps to avoid such an investigation in the first place. The following tips for health care practitioners are meant as practical suggestions only. Even if followed, there is no guarantee that an investigation will be avoided:



- Be suspicious of offers, discounts, free services, or cash incentives to order services or purchase equipment and have internal controls that identify who can authorize and make decisions on such offers on behalf of the organization.
- Protect patients' records to prevent theft or fraudulent disclosure by internal or third parties.
- Implement detailed record keeping for services and tests that are ordered as a way to ensure that they are necessary and actually rendered. Where applicable, specify the quantity of medical supplies or duration of medical services needed.
- Specify in writing why services or tests were ordered in case they are later questioned. Do not leave this documentation to the Medicare provider who files the claim.
- Make sure the health care practitioner personally completes all information on certification forms and never signs blank certification forms. The practitioner should never certify the need for medical services, equipment, or supplies for a patient whom the practitioner has not personally examined.

In some cases, doctors and hospitals hire a billing service or consultant to submit Medicare claims. Attorneys and clients should be aware that this does not relieve doctors and medical professionals of their personal responsibility for any overpayments received as a result of claims made on their behalf. Practitioners should oversee and review all submitted claims and perform careful background checks of individuals submitting claims on their behalf.

Help Clients Create a Compliance Plan and Culture

A good corporate compliance plan is an essential preventive measure for avaoiding fraud, and a practitioner's attorney can play a key role in helping shape this plan. The plan should address items such as: identify standards; detail reporting obligations and procedures; ensure effective auditing and measurement; and specify who will be in charge of implementing, managing, and reviewing the plan. Many organizations will opt to adopt a code of conduct that sets forth such roles and responsibilities at all levels of the organization.

All members of an organization should receive training on how to recognize fraud, abuse, and waste and learn how to report it. In addition, creating a "compliance culture"—by rewarding self-reporters, punishing habitual offenders, or having an anonymous tip reporting hot line, for example—may go a long way in the effort to avoid becoming the subject of a health care fraud investigation.

It would also be wise to counsel the boards of directors, partners, or other managers of health care clients to take proactive steps and to get involved in compliance efforts rather than delegating this responsibility entirely to staff. In addition to the obvious ramifications in the event of a director's or a partner's breach of fiduciary duties to the organization, a director or partner of an entity that is found to have committed health care fraud may also be personally excluded from receiving benefits under the government programs defrauded for a period of years, based on the mandatory exclusion provisions of the Social Security Act. Even absent any criminal conviction, the Department of Health and Human Services' Office of Inspector General (OIG) has the discretion to exclude providers from federal programs because of participation in a fraudulent scheme.

DHHS's Office of Inspector General has issued a number of notices providing guidance on compliance programs for various medical practitioners, including small-group physician practices, nursing facilities, and hospitals.[1] These notices provide guidelines on acceptable reporting practices, recommended internal policies, and factors to be considered when processing claims. In addition, DHHS's OIG maintains a supplemental Web page that lists compliance resource materials that attorneys may find helpful if they are newly faced with counseling clients in this area.[2] Even though it is likely that new compliance guidance may be issued in light of the recent health care reform efforts, these notices are nonetheless useful starting points and references for any attorney's health care practice.

Self-Reporting Potential Fraud

Preventive efforts aside, attorneys will want to have a good road map prepared for advising clients in the event the client suspects that its organization may have committed fraud. First, if there are reasonable grounds to support a client's concern that fraud may have been committed, attorneys should recommend that their clients retain qualified counsel to conduct an internal investigation. Based on the outcome of the investigation, if it appears that fraud or waste has been committed, the practitioner may decide to provide a self-disclosure to Medicare authorities. The guidelines for self-disclosure are set by the DHHS's Office of Inspector General, and the client's attorney will need to become familiar with these protocols.[3] Self-disclosure may enable a practitioner to avoid the costs and disruptions that could result from a gov-

ernment-led investigation and may help to minimize penalties. However, there is no guarantee that self-disclosure will allow an attorney's client to avoid prosecution in any particular case, because the self-disclosure process lies solely with DHHS and entirely outside the jurisdiction of the DOJ. If the potential fraud is significant, both the attorney and his or her client should probably expect some form of governmental investigation. Whether or not to self-report is a complex decision that should be made only after the attorney and his or her client have carefully considered the facts, circumstances, and applicable regulations and legal rules.

Clients Who Become the Target of an Investigation

In the event that a practitioner is the subject of a government investigation, the client should contact counsel immediately. Important decisions regarding strategy—such as whether to cooperate and/or testify and how to preserve applicable privileges (such as the Fifth Amendment privilege against self-incrimination)—should be made at the beginning of an investigation. In addition, attorneys will want to ensure that their clients avoid spoiling evidence intentionally or unintentionally—for example, by destroying documents or altering records. It may also be advisable to associate with co-counsel who has experience in handling complex government investigations, including federal criminal fraud matters, and who can help advise and provide guidance for both the attorney and the client through these difficult decisions and proceedings. **TFL**

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Endnotes

[1]Department of Health and Human Services, Office of Inspector General, *Compliance Guidance*, oig.hhs.gov/fraud/complianceguidance.asp.

[2]Department of Health and Human Services, Office of Inspector General, *Compliance Resource Material*, oig.hhs.gov/fraud/complianceresources.asp.

[3]63 Fed. Reg. 210 (Oct. 30, 1998).