

Keep cool

Review billing procedures, respond to worker concerns to avoid fraud scrutiny

In May 2009, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius formed the Health Care Fraud Prevention and Enforcement Action Team to fight Medicare fraud, which, they said, has become a top priority for both the Justice Department and HHS.

Additionally, the FBI announced in December 2009 that the joint Justice Department-HHS Medicare Fraud Strike Force, a multiagency team of federal, state and local investigators assembled to combat fraud through data analysis techniques, would expand into several metropolitan areas across the country.

As a former healthcare fraud prosecutor, I understand the chill providers are feeling. Reimbursement has shrunk significantly in the past few years, malpractice premiums are increasing, and pressure from federal regulators and law enforcement is eroding already frayed relationships between providers and patients. In this uncertain climate, providers need to know exactly what types of behavior will trigger an investigation, and how to protect themselves from unwarranted suspicion.

The healthcare industry, especially durable medical equipment companies and home-health companies, will be under the microscope. To spot offenders, the strike force usually begins by using Medicare data analysis techniques that look for “outlier” behavior. Outlier behavior is characterized by a pattern of billing procedures that are grossly inconsistent with industry competitors.

The government has access to billing records, and any company that is billing significantly more than competitors for a given item or service will probably face scrutiny. The Strike Force, however, is not intended in any way to suppress a healthcare provider’s ability to perform needed services. It remains extraordinarily difficult to base a healthcare fraud prosecution on allegations that a provider provided medically unnecessary services. And it should be. For example, providers that specialize in heart catheterization procedures and perform 10 times more of these procedures than their closest competitors should not be at risk of a federal prosecution based on the numbers alone.

A criminal case based on a lack of medical necessity requires a prosecutor to prove not only that the procedure was unnecessary, but also that the provider knew it. Such cases are



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extremely rare and will almost never include a provider with well-documented medical records and good backup.

Even outlier behavior in targeted industries will probably not be enough to trigger a criminal prosecution. Outlier behavior grabs the Strike Force’s attention, but prosecutions result only when there’s obvious fraudulent activity. The vast majority of criminal cases will involve outright kickbacks, bribes to patients encouraging them to visit certain clinics, billing for services not rendered and other egregious behavior.

Past Strike Force prosecutions and recent cases reflect this. For example, a recent Miami case involved a durable medical equipment company that billed Medicare for items based on prescriptions that did not exist. Another one allegedly submitted more than \$1 million in claims for durable medical equipment using forged prescriptions, forged certificates of medical necessity and the like.

Many fraud cases start with a disgruntled employee who unsuccessfully attempted to persuade the company to stop improper practices. In some cases, employees go directly to the government after being fired, while others work as informants from inside the company. Some former employees even return to the company at the government’s request so they

can gather information. Providers simply cannot afford to ignore employee complaints or fail to review policies and procedures for handling employee complaints.

Regardless of the type of inquiry, it is critical for a provider to immediately and carefully understand what happened, and to try and get answers quickly. The provider’s most fundamental task is to convince the government that the facts at most give rise to civil liability—not criminal prosecution—but this requires dexterity and full disclosure.

As a former task force prosecutor, I recall a case in which a provider allegedly billed an extraordinary amount of money for a certain type of visit. As I began to subpoena and interview witnesses, the attorney for the provider began his own investigation. The defense attorney was able to develop, and communicate to me, a reasonable explanation for why the provider’s behavior was not criminal. The result was a noncriminal solution that satisfied everyone involved. The provider implemented more stringent control and record-keeping measures, the government recouped its money, and the healthcare system did not have to lose a competent (but poor record-keeping) provider.

As the government turns up the heat on Medicare fraud, providers must work to ensure that all policies and procedures are above reproach. Not only should providers evaluate billing policies, but also they should pay close attention to employee feedback and make sure that credible internal concerns are resolved in an appropriate way. In the event that a provider comes under scrutiny, it is crucial that the provider take the inquiry very seriously and address it immediately to avoid aggravating a bad situation. In many cases, noncriminal resolutions are entirely within the realm of possibility—but require swift action. When it comes to Medicare fraud enforcement, forewarned is forearmed. <<

Jack Fernandez is a former assistant U.S. attorney, a founding member of the U.S. Attorney’s Health Care Fraud Task Force for the Middle District of Florida and a partner at the law firm Zuckerman Spaeder.

