

# MEDICAID COMPLIANCE NEWS

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

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## MICs Are Finding Few Recoveries, Sources Say; RACs Will Be 'MICs on Testosterone'

Audits by Medicaid Integrity Contractors (MICs) are under way in many states, with nearly 1,000 audits going and hundreds of millions in overpayments identified, CMS officials tell *MCN*. But health care attorneys and one state official say audits have not uncovered much — if anything — in their states and some express concern about the appeals process and future audits mandated by the health reform law.

MICs — part of CMS's Medicaid Integrity Program (MIP) that started receiving funding in 2005 — have initiated almost 1,000 audits in 32 states. The audits "are in various stages of the process," according to CMS's e-mailed responses to questions.

There are no concrete numbers for recoveries yet, CMS said. "At this point in time, we cannot speak to the amount of money recovered in this fiscal year by the states in response to the MIC audits as there is a lag time between the issuance of the final audit report to the state and the state's corresponding reporting of the recovery dollars to CMS," the agency explained. But the MIP's activities in FY 2009, which includes MIC audits, identified more than \$100 million in overpayments, CMS added.

One concern is whether CMS is getting a return on its investment, says one attendee at the Health Care Compliance Assn.'s recent Compliance Institute in Dallas. "The concern is that [CMS is] admitting to doing less than 1,000 audits in a program that's now approaching 10 months of operation for some contractors and over a year for others," says the attendee, who asked not to be identified by name.

*continued on p. 8*

## NY State's Huge Recovery Goal May Lead to Overzealous Audits, Say Medicaid Providers

Some auditors for the New York State Office of Medicaid Inspector General act like sole judge, jury and executioner, which has led to an adversarial relationship between OMIG and providers, according to some industry insiders. But Medicaid Inspector General Jim Sheehan tells *MCN* that he is "comfortable we [i.e., OMIG] are doing audits that need to be done" and are performing them according to professional standards.

According to state Sen. Craig Johnson (D), the integrity of the audit process is called into question when OMIG says it can achieve a \$1.2 billion recovery goal (the amount set in the 2010-2011 budget). It seems OMIG is telling providers it "will hit that number by any means possible," he said to Sheehan Feb. 9 during a budget hearing.

Sheehan explained to Johnson that this \$1.2 billion amount includes not just OMIG audits, but third-party payments, prepayment reviews and monies collected as part of the Federal-State Health Reform Partnership (F-SHRP) program. New York is obligated to collect \$644 million in fiscal year 2011 as part of the F-SHRP program (*MCN 2/10, p. 1*). This amount includes both federal and state monies and consists of money collected from OMIG, the Department of Health (DOH), the attorney general's office and voluntary disclosures.

Sheehan defended OMIG’s audit process and told Johnson it carries out audits according to DOH’s regulations. “We will not do something unethical or illegal,” he asserted. He tells MCN that he “respectfully disagrees” with the senator and defends OMIG’s actions since 2006 when it began auditing the four areas with the biggest expenditures. This was “overdue,” he says.

He also claims that New York’s track record in recoveries and prevention by both OMIG and the attorney general’s office is “better than any other state.”

He asserts that this backlash is a reaction to “what the legislature wanted to accomplish” by establishing the OMIG. Before 2006, providers just submitted payments to the state and nobody questioned them, he says. But “what was automatic in the past wasn’t anymore.”

OMIG doesn’t make up its own rules, Sheehan maintains. It follows and enforces the DOH regulations. Providers need to read these regulations, he contends. In fact, Sheehan notes, all provider agreements specifically state that providers will read the rules.

Johnson said providers admit they are not perfect, “but they live under OMIG’s rules.” But there are no rules for OMIG, argued Deborah Brown, vice president and special counsel for Greater New York Hospital Association. GNYHA and other trade groups representing hospitals, nursing homes and other health care providers, along with Johnson, testified at a hearing by the Senate Committee on Investigation and Government Operations March 17 that “in its zeal to recover funds...OMIG has become an abuser of sorts.”

**Providers Are Afraid to Speak Out**

OMIG officials have lost sight of their mission and don’t “have a real clue what they are doing,” said Neil Murray, general counsel for the New York State Health Facilities Association. In fact, he testified that the association’s providers were “unwilling to testify at the hearing because they were afraid” of repercussions by OMIG.

This sentiment was echoed by Christine Johnson, executive vice president of the New York State Association of Healthcare Providers. She described frustration with the apparent lack of communication between DOH and OMIG with regard to audit results. Many times providers will receive clean audits from DOH only to receive one from OMIG indicating problems with the same issues, she said.

Moreover, she maintained that there is a big problem stemming from the “adversarial relationship” between providers and OMIG. There is “constant anxiety” among providers, she explained, due to the long, time-consuming and expensive audit process regardless of the outcome.

Hundreds of thousands of dollars are being spent on attorneys’ fees and staff time to go through OMIG audits, claimed Johnson. As these resources are shifted to audits and away from patient care, she contended, patients are suffering and will continue to suffer.

Brown argued that there needs to be a difference in the way fraud cases and waste cases are handled by OMIG. There is a “large distinction,” she contended. When the media gets hold of these cases, there is a perception in the community that the particular providers are fraudulent, and that is not always the case, said Brown.

She also maintained that OMIG should reduce the number of audits it conducts of the same provider. Since August 2008, OMIG has posted 1,300 financial audits, she testified. The federal HHS Office of Inspector General posted 205 in that same time frame.

“This intensity can’t go on without significant implications for providers and their finances,” she said. The burden of preparing for these audits “falls to the same staff,” Brown contended.

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It seems OMIG can't win. In addition to coming under fire for being too tough on providers, it has been accused by the Republican Senate task force on Medicaid fraud that it is not doing enough to prevent it. "OMIG is between a rock and a hard place," says OMIG spokesperson Wanda Fischer.

The task force, designed to strengthen the state's efforts to fight fraud (*MCN* 3/10, p. 4), held its first hearing on March 8. During the hearing, OMIG and DOH were accused of not handing over Medicaid fraud information that would allow district attorneys to begin their own investigations.

Although witnesses at this hearing were more kind to OMIG, they still complained that there needs to be more access to information on Medicaid claims. Kathleen Rice (D), Nassau County district attorney, testified that her office "cannot proactively investigate and prosecute health care providers for fraudulently billing and stealing from Medicaid companies" because information obtained by OMIG "must go straight to the attorney general's office."

Sheehan tells *MCN* that the issue is weighing the need for privacy versus access to data. The "line isn't perfect," he says, but "we are addressing it and trying to strike the right balance."

The task force has recommended that all fraud cases be referred to local district attorneys in order to reduce the amount of time it takes to prosecute fraud, while allowing counties to keep a portion of all fraud recoveries they obtain.

In fact, there is a bill now pending in the state legislature (S. 4774/A. 10047) that would allow state agencies to provide referrals to investigators, including local district attorneys.

Contact Sheehan through Fischer at (518) 473-3782. For access to the March 17 hearing in its entirety, go to [www.nysenate.gov/committee/investigations-and-government-operations](http://www.nysenate.gov/committee/investigations-and-government-operations). ✧

## Civil Case Alleges That Hospital, Physician Harmed Cardiac Patients

Satilla Regional Medical Center in Waycross, Ga., and surgeon Najam Azmat, M.D., billed Medicaid and Medicare for medically substandard and unnecessary services, the Department of Justice alleges in a civil false claims lawsuit. The feds allege that one patient died and others were injured as a result of the alleged poor-quality care.

Clay Thomas, Satilla's director of planning and business development, told *MCN* sister publication *Report on Medicare Compliance* that the hospital denies the allegations and will vigorously defend itself.

The lawsuit was filed by Lana Rogers, a former nurse in Satilla's Heart Center cardiac cath lab. DOJ said it would intervene in the case on April 5. Satilla is accused of allowing Azmat to perform endovascular procedures in the Heart Center "even though he lacked experience in performing such procedures and did not have privileges to perform them," DOJ states. Nurses expressed concerns to hospital management that Azmat, who had a high complication rate, was incompetent, the feds allege. But Satilla let the procedures continue, along with the claims submissions, DOJ says.

The lawsuit describes Azmat's recruitment despite Satilla's awareness of alleged problems at his previous employer, Hardin Memorial Hospital in Kentucky. In 23% of Azmat's cases, Hardin found that "an intraoperative complication and/or postoperative complication had occurred," the complaint states. As a result, Hardin's medical executive committee requested a second opinion before all of Azmat's elective procedures and required a physician to assist Azmat when he performed major surgery.

These restrictions "were reported as an adverse action report to the National Practitioner Data Bank," the lawsuit contends. "Satilla obtained and reviewed" the adverse action report on Azmat, but granted him general surgery, thoracic surgery and vascular surgery privileges on Aug. 8, 2005. Satilla also allowed him to perform interventional angiography/arteriography procedures, including invasive peripheral intervention procedures in the cath lab, the suit alleges.

### Patient Abandoned, Suit Alleges

The complaint cites a litany of abuses, but DOJ limited its false claims allegations to certain endovascular procedures (such as stenting and balloon angioplasty, which improve blood flow through arteries) that were not reasonable and necessary. The DOJ press release notes, however, that it has intervened in Rogers' complaint, which alleges Azmat performed procedures in Satilla's Heart Center that he wasn't qualified or credentialed to perform, and that Satilla and Azmat submitted claims for the procedures. "As a result, at least one patient died and others were seriously injured," the press release states.

For example, on Jan. 19, 2006, Azmat attempted to perform a renal stent procedure in the Heart Center on patient Ruth Minter, the complaint states. Azmat allegedly perforated the patient's renal artery, "causing her to bleed out and eventually die." The lawsuit alleges that Azmat didn't fix the problem or arrange a timely patient transfer.

Instead, the complaint alleges, the surgeon abandoned the patient "and simply went to the operating room to perform another case, leaving Minter in the recovery room suffering from extremely serious and life-threatening complications." Eventually she was trans-

ferred by helicopter to another hospital, where she died from the renal artery perforation, the lawsuit alleges.

According to the amendments in the complaint, Satilla billed Medicaid for almost \$23,000 for the procedures performed on Minter. The facility received \$10,872 from Medicaid. Azmat submitted a separate bill to Medicaid totaling \$2,450 for the procedure on three different occasions, the complaint says. The maximum allowable payment he could receive for the services is \$511.82, it explains.

The whistleblower claims that Satilla pushed forward with billing for Azmat's surgery because its Heart Center was hurting for money after a legal dispute with staff cardiologists. In 2005, the Heart Center allegedly suffered a 35% drop in revenue. Satilla needed the revenue from Azmat's high-paying procedures, the lawsuit says.

Thomas says the whistleblower is a "disgruntled ex-employee." Rogers notes in the suit that she was fired

after repeatedly complaining about Azmat, but says she worked at Satilla for two periods of four years each.

Azmat left Satilla three years ago and was hired as a surgeon at a Veterans Administration hospital in Louisiana, Thomas says. If the government is so concerned about his competence and qualifications, he wonders, why would the VA, a government hospital, credential him?

Thomas adds that "Satilla Regional Center is in the top 10% of Georgia hospitals when it comes to caring for patients with acute myocardial infarction, congestive heart failure, community acquired pneumonia and surgical care." The integrity of the credentialing process and the physicians involved in it are "above reproach," he says.

To protect themselves and their patients, hospitals need effective credentialing and peer review procedures, says David Hoffman, a former assistant U.S. attorney who helped pioneer the use of the False Claims Act to

### *Louisiana Proposes More Provider Responsibility Under Medicaid*

Louisiana has decreased its improper payments by 222% since fiscal year 2005 and by 337% by FY 2007, according to a recent press release by the state Department of Health and Hospitals (DHH). But instead of resting on its accomplishments, the state has proposed transforming the Medicaid system to better deal with fraud, waste and abuse, and put more of the burden on providers.

DHH Sec. Alan Levine called the state's current Medicaid system one of "paying claims and asking questions later." He added that "taxpayers shoulder all the risk for fraud...We must change the design of this system to get taxpayers off the hook," he said.

According to Levine, one key factor contributing to Medicaid fraud is "the very design of the program itself." He referred to the program as a "pay and chase system," where providers bill Medicaid and the state just pays the bill.

Levine said the state has proposed transforming the system from a "fragmented, fraud-laden fee-for-service system toward a coordinated care model where every enrollee chooses a Medicaid provider network that is accountable for the funding, clinical care and clinical outcomes for their consumers."

Provisions in the new system include mandatory fraud detection and reporting by providers. This is the first time the system "will engage provider partners in the fight against fraud," DHH said.

DHH did not respond to a request for comments regarding specifics of the new proposed system.

Other accomplishments resulting from the state's crackdown on Medicaid fraud include increases in:

- ◆ **Identified improper payments** to more than \$6.2 million in FY 2009, up from \$1.9 million in 2005 and \$1.4 million in 2007.
- ◆ **The recovery rate of improper payments** from 84% in FY 2005 and 73% in FY 2007, to 93% in FY 2009, with collections increasing from \$1.6 million in FY 2005 to \$5.85 in FY 2009.
- ◆ **The number of recoupments** by 120%, from 234 in FY 2005 and 235 in FY 2007 to 516 in FY 2009.
- ◆ **The number of individuals** in the pharmacy and provider "lock-in" program by 23% from 1,020 in FY 2007 to 1,253 in FY 2009.
- ◆ **The number of cases** referred to the attorney general's office to 182 in FY 2009, up from 47 in FY 2005 and 71 in FY 2007.
- ◆ **The number of prosecutions** to 113 in FY 2009, up from 64 in FY 2005 and 82 in FY 2007.
- ◆ **The number of convictions** to 56 in FY 2009, up from 39 in FY 2005 and 44 in FY 2007.
- ◆ **The total judgments** obtained by the attorney general's office to \$19.8 million in FY 2009, up from \$17.7 million in FY 2005 and \$9 million in FY 2007.

For more information, visit [www.dhh.louisiana.gov](http://www.dhh.louisiana.gov) and click on "News." ◆

punish alleged substandard care. For example, how often are hospitals checking the National Practitioner Data Bank? How closely do they examine physicians' adverse action reports? "Once you start hearing about problems, does your internal system encourage professionals to come forward when they have concerns?" Hoffman asks.

"Do a root-cause analysis on a patient-by-patient case. We understand mistakes happen, but determine if there is really an issue of competence," he says.

If a hospital decides to give privileges to a high-risk physician, Hoffman says, "there must be supervision by competent colleagues." If necessary, micromanage the physician's diagnoses and surgeries, he says.

On the Medicaid side, Hoffman says there are more false claims cases alleging substandard care in the nursing home realm since Medicaid is the primary payer for residents (see story, p. 6). And many of those cases, which are generally handled by Medicaid Fraud Control Units, involve criminal charges.

"They have prosecuted neglect cases, and that's really what we're talking about. The foundation for all of these cases is neglect. The appropriate remedy flows from that finding," he says. "When they have reached neglect with a pattern of noncompliance that leads to resident harm, all remedies are appropriate."

Contact Hoffman at [dhoffman@dhoffmanassoc.com](mailto:dhoffman@dhoffmanassoc.com). Visit [www.justice.gov](http://www.justice.gov). ♦

## **Former Hospital Exec Improperly Obtained Medicaid UPLs, Feds Say**

The former president and chief executive officer of Archbold Medical Center in Thomasville, Ga., who served the facility for 34 years, was indicted April 8 for falsification of documents, among other charges. The documents were used to obtain Medicaid payments to which an Archbold facility was not entitled, the U.S. Attorney's Office for the Middle District of Georgia alleges in the indictment.

Kenneth Beverly also is charged with conspiracy to falsify documents and with witness tampering for allegedly trying to "corruptly persuade" Archbold CFO William Sellers, according to the indictment.

Archbold Medical Center is a system made up of five hospitals and four nursing homes. It operates Archbold Memorial Hospital (AMH), the system's flagship facility located in Thomasville, Ga. In 1981, the municipality established the City of Thomasville Hospital Authority under Georgia's Hospital Authority Act, but the indictment says the organization had no control over the day-to-day operations of AMH.

At issue are upper payment limits (UPLs), which are supplemental Medicaid funds for facilities designated as "public hospitals." Private hospitals would not be eligible. AMH began receiving UPLs in 2002.

Around that time, federal officials began to look into whether hospital authorities and the facilities they operate were governmental (i.e., public) or private entities. AMH was one of those under scrutiny, so the Georgia Department of Community Health (DCH), which administers Medicaid, was told to determine whether AMH was a public or private hospital under Medicaid rules.

AMH officials were told to provide documentation, including meeting minutes from the hospital authority, to demonstrate that the authority maintained operational control over the facility. The indictment notes that the hospital authority met only once between 2000 and 2004 to approve a financing matter. AMH's operational issues were not discussed at the meeting, it says.

"Defendant Kenneth Beverly and William Sellers knew that the Hospital Authority did not maintain operational control over Archbold Memorial, and therefore, did not meet the criteria to be classified as a public hospital under Medicaid guidelines," the indictment says. "Thus Archbold Memorial was not eligible to receive UPL funding." AMH received about \$4 million in UPL money to which it was not entitled, the feds allege.

The indictment also says that AMH received another \$5 million in payments under Medicaid's Indigent Care Trust Fund that it was not entitled to because it was a private facility, not a public one.

In an attempt to keep these payments coming, the feds charge that from January 2003 through November 2007, Beverly conspired to falsify documents and send them to DCH to make AMH look like a public facility. The indictment says Beverly discussed with Sellers the creation of fake hospital authority meeting minutes to send to state and federal officials. In February 2004, Sellers faxed the fake minutes to DCH officials who forwarded the documents to CMS.

In December 2004, Sellers faxed an "Attestations of Public Status" claiming that the hospital authority had control over AMH operations. That document also was forwarded to CMS. This conduct was repeated in 2005, according to the indictment.

### **Falsification Is Also Alleged**

Beverly is also charged with the falsifications of the documents. In addition, he is charged with two counts of witness tampering because he "did knowingly use intimidation, did threaten, and did corruptly persuade another person, William Sellers, and did attempt to do so, with intent to influence, delay and prevent the testimony of" Sellers in a pending civil case and any future

criminal prosecution, the indictment says. Finally, he is charged with making misleading statements to attorneys in a deposition.

An attorney representing Beverly refused to comment on the case. But Beverly released a statement to local media after he pleaded not guilty in court on April 14. Beverly said he “willingly participated in — and passed — a polygraph examination administered by a nationally renowned former Special Agent and polygraph examiner with the [FBI]. I am requesting an expedited trial so I can address the charges head-on, prove them false and move forward with my life,” he added.

Archbold Medical Center said in a prepared statement that the system self-reported the conduct to state and federal authorities when it first came to light “and conducted an investigation with the full knowledge and cooperation of state and federal officials.”

Although the indictment says Beverly and Sellers discussed sending the fake documents, Sellers is not charged in the case. The indictment does not specify whether Sellers came forward to Archbold or federal officials with the information, though it appears that he cooperated with investigators.

There’s no substitute for good employees, even with a compliance program, says former federal prosecutor Kevin Egan, who is now with Foley and Lardner. “All you can do is hire good people. Make sure the CEO is honest and honorable. Their bosses are the board of directors....It was their job to watch Beverly. But they’re not going to sit down with his books to see if he’s defrauding Medicaid. So all you can do is hire well and hire the best you can.”

A culture of compliance at Archbold probably should have encouraged Sellers to come forward, Egan adds. “Who knows how vibrant their compliance program was? You’d think it would have kicked in. Can people hide things when they’re going along with the boss? They sure can.”

Contact Egan at [kegan@foley.com](mailto:kegan@foley.com). ✧

## **Georgia Nursing Homes Provided Worthless Services, Feds Say**

A married couple who owned and operated a group of nursing homes in Georgia has been charged with conspiring to defraud Medicaid and Medicare while residents went without food and medicine, the U.S. Attorney’s Office for the Northern District of Georgia said April 16. Employees and vendors also went without payment at times, so the facilities allegedly had low staffing levels and did without necessities such as electricity.

George Houser was the owner and CEO of Forum Healthcare Group, Inc., based in Rome, Ga. His wife, Rhonda Houser, was the corporate secretary for the company. The firm included the Mount Berry, Moran Lake and Wildwood Park nursing and rehabilitation centers. The Housers “managed all of the details of the nursing facilities’ administration,” from 2004 until they were shuttered in 2007, the indictment says.

The nursing homes served about 300 residents while they were operating, and nearly all of them were Medicaid or Medicare beneficiaries, the feds say. They received about \$30 million over the years from Medicaid and Medicare billings. “From June 1, 2004, until on or about September 7, 2007, the Nursing Facilities submitted or caused to be submitted false or fraudulent claims to the Medicare and Georgia Medicaid programs for services that were worthless in that they were not provided or rendered, were deficient, inadequate, substandard, and did not promote the maintenance or enhancement of the quality of life of the residents of the Nursing Facilities, and were of a quality that failed to meet professionally recognized standards of health care,” the indictment alleges.

### **Employees Told Owners About Problems**

The feds say there was a revolving door of administrative employees at the facilities, but that many of the administrators communicated with the Housers about conditions at the nursing homes. “Yet the defendants affirmatively ignored these alerts, sometimes throwing away faxes from the administrators without ever reading them. Some of the administrators quit due to their frustration about the defendants’ lack of concern about the substandard conditions at the facilities,” the indictment says.

Staffing levels in general became an issue once payroll checks started bouncing regularly in late 2004, the feds say. This continued through 2005 and 2006, and nursing staff refused to stick around, so the facilities did not have enough people to take proper care of the residents, court documents say.

The Housers also owed “considerable sums” to vendors and “curtailed crucial services provided to residents by failing to pay the vendors who provided such services,” the government alleges. Bills for things like food, clinical lab services, medical waste disposal, trash disposal, pharmacy services, and other nursing supplies, as well as repair costs for water heaters, air conditioners and a leaky roof went unpaid, according to the indictment.

“The Nursing Homes were always suffering from food shortages,” the indictment contends. “Based on the number of residents at Mount Berry and Moran Lake, the two facilities were spending significantly less on food per resident than the national average.” After one food ven-

dor refused to serve the homes because it was not being paid, the company switched to Sysco Food Services.

"Sysco constantly had problems with payments and a number of times notified the defendants that the accounts were seriously past due and that they might not be able to continue supplying food. In response to Sysco's concerns, in June 2006, [George Houser] sent Sysco a signed personal financial statement dated as of May 2, 2006. The personal financial statement indicated that [his] net worth was more than \$26 million," the indictment says.

The local power company, Georgia Power, was owed \$283,000 for the Mount Berry and Moran Lake facilities by the time they were closed in 2007. The feds say the Housers would make arrangements with the power company to make payments, but would not follow through. "Georgia Power was reluctant to immediately cut off the power usage and utilities at the facilities because it was aware that the facilities were nursing homes," the indictment states. Instead, it started cutting electricity off in areas of the homes that it believed would not directly impact residents such as in the laundry room and storage areas, and even at Forum Group's corporate office.

The Georgia Department of Human Resources Office of Regulatory Services (ORS) was in charge of surveying the facilities to ensure compliance with federal and state regulations. Around May 2007, the volume and severity of complaints from residents' families, staff members and vendors triggered a survey at Moran Lake and Mount Berry. "The nursing facilities had numerous problems that were documented by repeated cited deficiencies in the ORS surveys, including significant weight loss by many of the residents," the indictment says.

### Five Major Problems Found

Five "immediate jeopardy" marks were given, which means the "provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Among the problems the state identified were:

- ◆ **Sanitary conditions** in food preparation and service;
- ◆ **Failure to correctly handle** and process laundry that prevented spread of infection;
- ◆ **Failure to ensure provision** and/or payment of basic necessities for kitchen and laundry sanitation, as well as dietary and environmental needs of residents; and
- ◆ **Failure to maintain a quality** assurance program to identify and implement corrective measures.

In a June 8, 2007, letter, the Moran Lake and Mount Berry facilities were given a plan of correction with remedies they were required to take by June 15. On that date, they received another letter notifying administrators of their involuntary termination from Medicaid and Medicare.

Auditors visited the Wildwood facility on Aug. 20, 2007, and found that some immediate jeopardy problems were corrected, but that the facility still was not in substantial compliance with federal requirements. Wildwood administrators were told to follow a plan of correction. Auditors returned on Sept. 4, but still found problems. On Sept. 10, the state notified Wildwood of its involuntary termination from Medicaid and Medicare.

The indictment includes charges of failing to pay payroll taxes and failure to file individual income tax returns.

Attorneys representing the Housers could not be reached for comment.

Visit [www.usdoj.gov/usao/gan](http://www.usdoj.gov/usao/gan). ✧

## Pediatricians Settle Allegations Involving 'Special Services' Code

A pediatric medical practice headquartered in Trumbull, Conn., has agreed to pay almost \$75,000 to resolve allegations that it submitted improper Medicaid billings using a "special services" code, the U.S. Attorney's Office for the District of Connecticut said April 6.

Pediatric Healthcare Associates (PHA) has offices in several Connecticut communities, including Bridgeport, Fairfield, Shelton, Southport and Stratford. The group's website says it has been serving the communities for more than 50 years.

The feds say the practice submitted billings for CPT code 99050, which covers services requested after a provider's posted office hours, at times other than regularly scheduled office hours, or on days when the office is normally closed such as holidays and weekends. "When services such as office visits are provided on days when the office is normally closed or after a provider's usual office hours, a provider is permitted to bill an add-on code and receive an extra payment, in addition to the payment for the underlying services," the government says in a press release.

The U.S. attorney's office alleges that PHA routinely billed for the code when it was not closed, but was open for business and was regularly scheduling patients. The conduct occurred between January 2004 and March 2009, according to the settlement. "During part of the time period in question, PHA had hours posted on its website indicating that its offices were open in the evenings until 9 p.m. on most weekdays, and that the practice was open and had regular hours on Saturdays and Sundays," the press release says.

The feds cite 2006 guidance by the American Medical Association about when to use an add-on code. "A patient develops severe ear pain that is unresponsive to

home treatment. Late Monday evening after the office is closed, the physician agrees by telephone to meet the patient in the office to provide treatment," it says. "CPT code 99050 is reported in addition to the basic service." Guidance from the American Academy of Pediatrics also says that the codes cannot be used when a physician and staff members plan to be at the office and available to see patients who may require care, albeit previously unscheduled.

PHA's site now says that some of its offices have evening hours only during the summer months, and that weekend and holiday visits are for emergencies only.

A spokesperson for the U.S. attorney's office says PHA did not self-report the conduct, but he declined to comment on the case further. According to the settlement, the parties agreed to settle to avoid the delay, uncertainty, inconvenience and expense of litigation. PHA denied liability as part of the settlement. At \$74,644, PHA is paying double damages (the False Claims Act provides for up to treble damages).

### Practice Denies Allegations

In a prepared statement, PHA says it denies any wrongdoing. "The government took issue with our use of after-hours coding for night-time and weekend care because, they said, our office remained open at night and on weekends and thus our evening and weekend office hours constituted 'normal business hours'. We believed that night-time and weekend urgent care constitutes after-hours care," PHA says.

"We further believed, and continue to believe, that keeping sick children *out of hospital emergency rooms* at night and on the weekends by maintaining evening and weekend office hours serves a much greater purpose and saves taxpayers millions of dollars by delivering the most competent, professional and personalized pediatric care within the confines of a doctor's office," the group continues.

"[We] understand the need for the government to zealously pursue repayment from those providers who file false claims for reimbursement claims or otherwise abuse the reimbursement system. We categorically deny that we filed false claims or otherwise abused the reimbursement system," PHA says.

"We chose to settle with the government rather than engage in a long and expensive legal battle. We intend to advocate for a clarification in both the laws and the CPT codes associated with after-hours care so as to avoid further confusion in interpreting these codes and the unintended consequences that might otherwise result from our unfortunate experience," it adds.

Visit [www.justice.gov/usao.ct](http://www.justice.gov/usao.ct). ↵

## MICs Turn Up Few Recoveries

*continued from p. 1*

Some providers also fear MICs, the attendee says. There was a lack of education about the program, and providers aren't forewarned before an audit. "Providers don't really have a relationship with MICs until they get a negative letter [asking for medical records and alleging overpayments], and then they get nervous."

In Maryland, there have been fewer than 20 audits, and the process is slow, says Pam Owens, assistant inspector general for the state Department of Health and Mental Hygiene. "We have had approximately 15 engagements with providers in the last 18 months," she tells *MCN*. Of those, only three probes remain open, she says. "I'm quite certain that the audits will get faster. It takes time because there are a multitude of parties involved, and we're trying to ensure that we are not stepping on each other. We have to understand every regulation the provider operates under. It takes quite a bit of time before we even engage the provider," she explains.

The convoluted process of MIC audits involves "review MICs" (which Owens has begun calling "data analysis MICs"), which comb through the Medicaid Statistical Information System (MSIS) data and refer any anomalies to CMS and state Medicaid integrity officials. The state checks to see (1) whether the provider is already being audited by the state, or (2) whether there is some easy explanation for the anomaly such as nuances in state Medicaid payment policies (*MCN 2/09, p. 1*).

If the state gives the thumbs up, CMS gets the "audit MIC" involved and decides on a general audit or more focused probe. The MIC engages the provider via a letter and asks for records by a certain date.

### Feds, States Tried to Simplify

CMS was "really good about coming to the states, paving the way for what was going to happen and working closely with us to hammer out the details so we could work with each other and avoid undue hardship on providers," Owens says.

MIC audits in Pennsylvania haven't produced big recoupments, says Paula Sanders, a Harrisburg attorney with Post and Schell. "We have gone through a whole series of them already," she tells *MCN*. "It was not very successful from the perspective of return on investment," but that may be because there was a learning curve, she says.

"The first go-through in Pennsylvania was extremely frustrating. I had a number of clients receive target [notification] letters. The auditor was using a very limited dataset," says Sanders. She explains that nursing homes in Pennsylvania are paid through a prospective payment sys-

tem. The time period the MIC cited in its letters coincided with a retroactive rate adjustment and some changes to the Medicaid program’s computer systems, she says.

“So there were a lot of claims adjustments that were being done, but because [the MIC] took a small segment, it did not ask for the entire claims file before it issued the target letters. So it looked to [the MIC] like there was going to be a huge recovery...because some providers were filing four to five claims for the same patient. It would look suspicious,” she says.

The MIC identified 118 potential targets in Pennsylvania, but sent letters out to only 46, Sanders says (see table, this page). So far, collections total \$4,856 in the state, but not all of the audits are done.

Sanders adds that she also has clients located in Delaware who received letters from the MIC, but no recoveries came from those probes. “I would be curious to see where recoveries [that CMS is reporting] are coming from. Some states have much more robust Medicaid integrity programs than others,” she says.

There has been a lot of MIC activity in the western half of the country, including in Arkansas and New Mexico, says Sarah Kay Wheeler, a partner with King and Spalding. “Right now, the providers that have gone through [audits] are just trying to get their arms around them,” especially if it was a field audit, she tells *MCN*. “The logistics just have to be worked out — will records be copied or is the MIC on site making findings? I have seen different approaches. If they’re on site, you would think they wouldn’t need copies. But there have been requests from at least one MIC who was doing a field review to have the records copied while they were there.”

**Long Appeals Process Is Expected**

“The majority of the audits we’ve seen have not progressed yet to the point of any final recovery. The MICs are actively reviewing records, and those vary significantly as to number and how far back,” Wheeler says. “There is a wide variety of issues being looked at. At hospitals, short-stay cases are on MIC radar, as they are for RACs and MACs...I think the way they are progressing, we will have some [appeals] this summer,” she predicts.

Owens gives a hint to how MIC appeals might work. “We have a procedure we have worked out with CMS. [Appeals] will fall back into our regular state system as if my division did the audit,” she says. The MIC will write an audit report and send it to Owens’s unit in the health department’s inspector general’s office. “We will distribute it among the stakeholders here and make sure the MIC didn’t misinterpret something. We say whether [we think] the audit results are sound,” she says. “Assuming that everything is well in hand, our program will

put a recovery letter on top of the audit report and send it to the provider, requesting them to return the money to the state. If they appeal, it goes into the regular state appellate process. Our attorney general’s office handles the appeal. So the only place it would differ from my unit doing the audit is that someone from [CMS] will come and defend their audit product,” she explains.

Wheeler predicts that appeals will take a long time. While RACs have a timeline for appeals, “with MICs it’s going to take longer — maybe four to six months. Maybe once they get some experience, it may move more quickly in the future. But with the first round of appeals in each state, it is going to take some time,” she says.

**Number of Records Is a Common Complaint**

State laws are complicating matters as well, Sanders says. For example, record requirements in MIC audits are governed by the state laws rather than one standard federal requirement, as is the case in Medicare recovery audit contractor (RAC) reviews. And unlike MICs, RACs have a cap on how many records they can request. “In Pennsylvania, we had about two weeks to provide the records, and there was no limit to the number of records.”

What’s more, RACs have a three-year cutoff, whereas MICs could ask for 100 records going back five or six years, and providers would have just the 14 days to produce them, says Sanders. “[Providers] could call and ask for an extension, and they were generous and gave you a week. I think that’s a huge issue. And [providers] could be under multiple audits simultaneously — they could have a RAC and a MIC audit on different topics,” Sanders points out.

Although Owens has not heard of providers complaining about why they’re being audited or the number

<b>Pennsylvania Medicaid Integrity Contractor Audits as of March 31, 2010</b>			
<b>Provider Type</b>	<b>Number of Audits Initiated</b>	<b>Closed/No Action</b>	<b>Number of Providers Still Under Review</b>
Inpatient	5	1	4
Long-term care	20	19	0
Clinic	1	0	1
Inpatient psych	1	1	0
Pharmacy	13	2	10
Physician	3	1	2
Residential treatment facility	3	2	1
<b>TOTAL*</b>	<b>46</b>	<b>26</b>	<b>18</b>
*The difference in the total may be due to duplicate engagement letters received from the Audit MIC. SOURCE: Post & Schell, P.C.			

of records MICs ask for, she says they have received comments on the use of the MSIS data. "If a provider gets a list of claims from an auditor and an MSIS number is listed, they are not going to be able to match that in their system. So it's the manner in which the audit teams are requesting the information, not the amount that is being requested," she says. "MSIS data can be difficult to use, not just for auditors and program integrity [people], but also for the provider."

Previously, providers have complained that MICs don't have enough knowledge and experience to conduct the audits (*MCN 10/09, p. 4*).

CMS says concerns it has heard from providers "involve lack of readily available information about the audit process, time frames for providing medical records for review, and a perceived lack of coordination of the audits with the state and other audit contractors (e.g., Medicare contractors, state or federal law enforcement audits)." CMS says it has been working with the states and providers to improve communication and outreach and address time frame issues on a case-by-case basis.

On top of all of this, providers are facing more federal audits once RACs become involved, as was man-

dated by the health care reform law President Obama signed in March (*MCN 4/10, p. 1*). Owens says she thinks there won't be audit duplication because she predicts that RACs will oversee the acute-care setting, with MICs restricted to outpatient algorithms.

Others are not so sure. "It's going to be dueling audit groups," says Joanne Erde, an attorney with Duane Morris. "They're all going after the same data, and it's going to be very interesting because...it would appear that the MIC rollout has been a slow, deliberate process. They [created] an infrastructure, did test audits, had extra staffing, and rolled it out very slowly. One might hope this was all intended to make sure they are not burdensome so they're effective without being overzealous," she says.

In contrast, "the [Medicare] RAC demonstration was the wild, wild West, and it was a terrible experience for the hospitals involved," Erde tells *MCN*. "Appeals are at a very high cost. There is no reason to expect that Medicaid RACs are going to be much better. It's going to be a new level of reviewing scrutiny. It just piles on higher and deeper," she says.

"I absolutely think it's going to be challenging from a provider and state standpoint in terms of how many

## ***CMS Reorganization Moves Program Integrity Up as Priority***

CMS has restructured itself to include a Center for Program Integrity, under which both Medicaid and Medicare integrity operations now fall. The new department reports directly to the CMS administrator. Other program-integrity functions such as recovery audit contractors, medical reviews and comprehensive error-rate testing, remain in the Office of Financial Management.

Peter Budetti, M.D., who has been appointed deputy administrator for program integrity, told attendees at the Health Care Compliance Assn.'s Compliance Institute that the new department "has every intention of doing the most efficient and effective activities we can."

Budetti outlined four "strategic principals" at the HCCA conference on April 20:

**(1) Tailor interventions to areas of the worst fraud and abuse.** This could be geographic or focused on goods and services that are most vulnerable to fraud or abuse. "We won't do a one-size-fits-all approach," he says. "We want our interventions to fit perceived problems. There are different interventions for organized crime and systematic health fraud, but there are many, many other issues to be dealt with and

many other ways to prevent problems than the law enforcement tail end of things."

**(2) Improve Medicaid and Medicare program integrity operations.** One reason for the creation of the Center for Program Integrity was to bring together Medicaid and Medicare activities. Budetti said CMS's goal is to have consistent "policies and interventions" across the two "very large and quite different programs. We don't want conflicting, duplicative policies or procedures" in the program-integrity arena.

**(3) Strengthen prevention of improper payments at the front end of claims-payment systems.** There are initiatives to screen providers to ensure they deserve to be enrolled "but not in a way that interferes with keeping legitimate providers in Medicare."

**(4) Enhance private-sector partnerships and share fraud detection and prevention methods.** CMS is moving to establish more effective relationships with anti-fraud groups, provider groups, private payers and beneficiaries. "This is something we need to view as a collaborative activity," Budetti said. Providers who abuse one payer probably abuse other payers.

*This story was excerpted from MCN's sister publication Report on Medicare Compliance.*

different players are viewing the Medicaid dollars," says Wheeler. "At what point is the burden going to outweigh the benefit of recoveries? Are MICs expected to know the 16 or 17 different [state] programs in their region? I think there will be opportunities for missteps."

Sanders points out that the two audit programs are structured differently. "The overall difference between RACs and MICs is that RACs are looking universally. They identify an issue and go after people. MICs are really looking at aberrant practices. The needs are different," she says. "One can only hope that now that Medicaid is going to be co-located with the [newly created] Center for Program Integrity, there will be more dialogue between the two programs" (see box, p. 10).

"One begins to think at some point that there will be saturation overload," Sanders adds. "I don't know what RACs are going to do — if they're going to follow state laws as far as number of [medical record] copies, time frames, look-back periods... This could be MICs on testosterone because there will be fees involved. It's overwhelming."

Sanders suggests that if CMS is finding that high overpayments are concentrated in certain areas, it might make

more sense to target certain areas, as the joint HHS-Department of Justice HEAT program has done. "I just don't know how it all plays out at the end of the day. If you're in a state that has good controls in place, you have your bureau of program integrity, and your MFCU [i.e., Medicaid Fraud Control Unit], etc... Where does it stop?"

CMS says it's too early to tell what impact Medicaid RACs will have on other audit activities. For example, "a lot depends on whether state law changes need to happen and in what states ([which] affects how quickly state-level contract procurement actions will take place), federal guidance and regulation, and whether CMS will have a more difficult time attracting [MICs] who are not contingency-fee based," CMS told MCN.

"There is an expectation that there [will] be a coordination of efforts, so we are sensitive to provider burden if multiple different auditors are seeking information simultaneously."

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## NEWS BRIEFS

◆ **Four error types make up almost 80% of inaccurate billings and 95% of the net improper Medicaid overpayments in the Payment Error Rate Measurement (PERM) program**, OIG said in an audit report (A-06-09-00079) posted April 14. These four error types were insufficient documentation, no documentation, services that violated state policies and medically unnecessary services. OIG analyzed 1,356 medical review errors in 23 service categories. Six of those categories made up 67% of the errors: nursing facilities, inpatient hospitals, other services (home and community-based services waivers), intermediate care facilities for the mentally retarded, prescribed drugs and physicians. OIG recommends that CMS develop and provide to states analytical data similar to that contained in OIG's report and encourage states to use the data to help ensure proper payments. To read the report, visit AIS's Government Resources at the Compliance Channel at [www.AISHealth.com](http://www.AISHealth.com), and click on "OIG Office of Audit Reports."

◆ **The Ohio attorney general's office alleges in a civil lawsuit that a large nursing home operator overstated some expenses when it billed Medicaid**, the AG's office said April 7. Carington Health Systems received

Medicaid overpayments for 21 of its facilities, the AG said. The amount the company received will be determined in court, an AG spokesman told MCN. Nursing facilities are required to report their costs for supplying services to residents, and the Ohio Department of Job and Family Services uses those cost reports to calculate a per diem rate for Medicaid reimbursement, the AG's office explained in a prepared statement. The suit alleges that Carington over-reported certain consulting service expenses in its 2003 cost reports resulting in inflated per diem rates for fiscal years 2005 through 2010. A Carington spokesperson could not be reached for comment. Visit [www.ohioattorneygeneral.gov](http://www.ohioattorneygeneral.gov).

◆ **OIG has dedicated a portion of its website to Medicaid Fraud Control Units (MFCUs) to "better showcase the important role played by" the units**, OIG said April 22. OIG oversees MFCUs, which are funded on a matching basis by the federal government and states as part of Medicaid. OIG also will begin posting press releases of MFCU enforcement actions. Visit [www.oig.hhs.gov/fraud/mfcu](http://www.oig.hhs.gov/fraud/mfcu).

◆ **Federal agents raided a clinic owned by New York state Sen. Pedro Espada (D) the day after the**

**NEWS BRIEFS (continued)****state's attorney general (AG) filed a civil lawsuit against the legislator alleging that he is siphoning funds from a nonprofit clinic for personal use.**

Investigators from the FBI and IRS took boxes of documents from the Bronx-based Soundview Healthcare Network, the *Crain's New York* website reported April 21. The AG's lawsuit "seeks to permanently remove Espada and to remove all of Soundview's directors from the board," which is "packed" with Espada's family members and friends, a prepared statement from the AG explains. Soundview receives funding from the state and federal governments to provide affordable health care to citizens in the South Bronx, the AG's statement says. The suit says the organization's officers and directors approved a \$9 million severance package for Espada that guarantees him one year's gross pay for every year of service, which if triggered, would force Soundview into bankruptcy. It also alleges that funds from Soundview are used to pay for restaurant bills, trips and items for Espada's campaign. Espada told local media that the suit is politically motivated. Read the lawsuit at [www.ag.ny.gov](http://www.ag.ny.gov).

**◆ The New York attorney general's office is attempting to seize millions of dollars allegedly billed by "Medicaid mills" that are owned by a businessman and dentist from the former Soviet Union, the**

*New York Post* reported April 12. Investigators also seized computers and records from three dental clinics three weeks after *Post* reporters followed patient recruiters offering to pay Medicaid beneficiaries \$20 or more to receive a dental cleaning or other work. The *Post* reports that court documents say the clinics billed Medicaid for about \$7.2 million between January 2007 and March 2010. Four dentists who worked for the clinics now are cooperating with the state, the *Post* says. Read more at [www.nypost.com](http://www.nypost.com).

**◆ Two former employees of a Brooklyn Park, Minn., personal care provider pleaded guilty April 28 to charges related to health care fraud, according to**

the U.S. Attorney's Office for the District of Minnesota. Both women and their employer were indicted in October 2009. In a plea agreement, Sabrina Peterson admitted that she conspired to defraud Medicaid by submitting false claims between September 2007 and October 2009 for services that were never rendered. The other defendant, Crecida Cade, made similar admissions. The owner of the company, Patrick Osei, pleaded guilty April 20 to offering and paying out a

kickback to induce referrals to the company in an effort to obtain Medicaid reimbursements. The feds estimate that the scheme cost Medicaid between \$200,000 and \$400,000. Visit [www.justice.gov/usao/mn](http://www.justice.gov/usao/mn).

**◆ The former CEO of an Alvin, Texas, nonprofit medical organization has been indicted on two Medicaid fraud-related charges, the Texas attorney**

general's office said April 9. Nancy Benefield ran Alvin Community Health Endeavor Inc. (ACHE). She is charged with misapplication of fiduciary property of more than \$200,000 and theft of more than \$20,000 (but less than \$100,000), according to the AG's office. ACHE serves Medicaid beneficiaries. The AG alleges that Benefield "diverted Medicaid funds for her personal benefit," directed employees to falsify CMS billing statements and failed to comply with federal guidelines for administration of the facility. Investigators estimate that Benefield defrauded about \$236,000 from Medicaid, the state says. Visit [www.texasattorneygeneral.gov](http://www.texasattorneygeneral.gov).

**◆ Former dentist Robert Louis of Spanish Fort, Ala., pleaded guilty April 22 to three counts of attempting to defraud Medicaid, according to the**

Alabama attorney general's office. Investigators found that Louis approached administrators at schools in three Alabama counties in 2008 and offered to perform free dental screenings. He then billed Medicaid for the services, but the state says he either never performed them or they were not eligible for reimbursement. The state's Medicaid agency noticed the conduct and alerted the MFCU, so there was no monetary loss to the state, the AG's office says. Louis received six years probation. As part of his plea agreement, he surrendered his dental license for life. Visit [www.ag.alabama.gov](http://www.ag.alabama.gov).

**◆ New York's MFCU reported a record year of more than \$283 million in recoveries in 2009, according to the unit's annual report released April**

**12.** The MFCU also obtained 148 criminal convictions during 2009, opened 337 new investigations and completed a total of 357 probes. Of those that were completed, 84 were resolved through criminal prosecution, 161 were resolved through civil actions, 13 cases were referred to other agencies and 99 were closed due to insufficient evidence. Read the full report at [www.ag.ny.gov/media\\_center/2010/apr/mfcu\\_2009.pdf](http://www.ag.ny.gov/media_center/2010/apr/mfcu_2009.pdf).

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