Health Care Fraud FCA Prosecutions in the Southern District of Texas

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Disclaimer:

- The opinions expressed herein are my own, and NOT those of the Department of Justice OR the U.S. Attorney's Office for the Southern District of Texas

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Topics

- Southern District of Texas
- Recoveries
- Common Types of Cases in the Southern District of Texas
- Inside the Investigation
- Evidence
- Deterring Fraud within Your Organization

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Southern District of Texas

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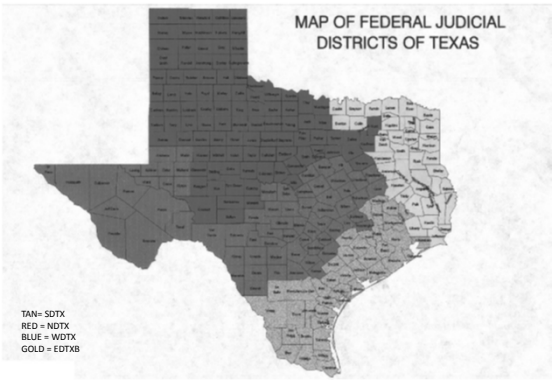

Southern District of Texas

- Population – close to 7 million people
  - Major population centers:
    - Houston / Galveston / Victoria / Huntsville
    - Corpus Christi
    - The Valley – Brownsville / McAllen / Harlingen
    - Laredo
      - Substantive number of Providers within these populations centers
- One of the largest Districts by population in the United States and growing fast
- Second largest District in number of filed indictments

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The Southern District of Texas

- Offices in all major population centers:
  - Houston – 131 attorneys
  - Corpus Christi – 15 attorneys
  - Brownsville – 19 attorneys
  - McAllen – 22 attorneys
  - Laredo – 18 attorneys
  - Total: 205 attorneys

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Health Care Fraud Attorneys:

- Civil Division – Affirmative Civil Enforcement
  - 5 attorneys
- Criminal Division – Health Care Fraud Task Force
  - 6 attorneys
- Criminal Health Care Fraud Prevention and Enforcement Action Team (HEAT)
  - 2 attorneys
  - 3 part time attorneys (DC based)

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Sources of Health Care Fraud Cases:

- Civil Division
  - Qui Tam / FCA Complaints
  - Referrals from the Criminal Division
  - Agency Referrals
    - HHS-OIG / FBI / RACs / ZPICs
    - State
- Criminal Division
  - Agency Referrals
    - HHS-OIG / FBI / RACs / ZPICs
    - State
  - Referrals from Civil Division
    - Qui Tam / FCA Complaints
      - Parallel proceedings

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Recoveries

Southern District of Texas

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Affirmative Civil Enforcement :

- Dedicated Section formed in 2002
  - Recent SDTX Annual Recoveries (health care and non health care):
    - 2008 $ 46,100,000
    - 2009 $ 34,037,000
    - 2010 $ 90,601,000
    - 2011 $ 23,500,000
    - TOTAL: $194,238,000

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SDTX – Health Care Related Recoveries:

2008	
Health Care Fraud	$38.3 million
Drug Diversion	$ .3 million
2009	
Health Care Fraud	$34.0 million
2010	
Health Care Fraud	$39.6 million
Fraud Injunction Statute	$36.0 million
2011	
Health Care Fraud	$ 8.5 million

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Current Civil Enforcement Cases in the SDTX:

- Working approximately 55 qui tam cases
- In 2012 have received approximately 1 new qui tam per month
- 80% of these qui tam cases are health care related

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Why devote the resources to Health Care Fraud cases?

- Substantial return on investment
  - In SDTX 4 to 5 attorneys generated $120.4 million over past 4 years doing civil Health Care Fraud cases
- Substantial amounts of fraud
  - Estimates of the amount of health care spending lost to fraud vary between 3% and 10 % of total health care expenditures – or between $68 and $226 billion annually

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Common Types of Civil Cases in the SDTX

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Qui Tam filings provide the majority of cases :

- Over-Utilization
  - Medically unnecessary tests and services
    - Across all specialties
      - Cardiology / MLD / CT Scans / MRIs / Wound Care / PT / HH / Hospice / DME
        - McAllen, Texas – Poster Child for Over-Utilization
- One-Day Stay Cases
  - Improper in-patient admissions
    - Inappropriate admissions through the ED
    - Failure to use observation status
    - In-patient orders after out-patient procedures

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Cases (cont'd):

- Unbundling
  - Specialty Surgery Centers
- Kickback / Stark
  - imaging centers / dialysis clinics / acute care
  - providers – hospitals
- Billing for Services not Rendered
  - home health /physical therapy clinics / DME

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Inside the Investigation

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Assessment of the Relator

- Interview Relator:
  - Still employed
  - Fired
  - Resigned
  - Position
  - How long
  - Criminal history
  - Credit history
  - Prior history of litigation
  - Credible allegations given position
  - Quality of evidence in the written disclosures
  - Participated in fraud now complaining about
  - Motive for filing

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Assessment of the Fraud:

- National, regional, or isolated problem
- Complexity of regulations at issue
- Dollar amount involved
- Financial strength of defendant
- Quality of care issues
- Defendant's knowledge of fraud and reaction or response
  - This assessment will determine whether a criminal investigation will also be opened

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Using the Relator:

- Documents that would substantiate fraud
  - Documents to request
- Witnesses that will substantiate fraud
  - Questions to ask
- Document review & analysis
  - Common Interest Agreement to share documents

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Who becomes a Relator (Whistle Blower)?

- Anyone and Everyone – in my cases:
  - Physicians (largest group)
  - Compliance Officers
  - Nurse Case Managers
  - Coders
  - Billing Personnel
  - Physician Office Managers
  - Marketing Representatives

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Investigative tools:

- Civil
  - Inspector General Subpoenas
    - Documents
  - CIDs (civil investigative demand)
    - Sworn oral testimony, documents, interrogatories
  - Interviews
    - Former employees first

Criminal
  - Search warrants
    - Documents
  - Grand Jury subpoenas
    - Sworn oral testimony, documents
  - Interviews

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Analysis:

- Data Mining
  - Claims Data Analysis
  - Peer Reviews
- Medical Reviews
  - Billing error rates
  - Statistically valid stat samples
- FMV Studies
  - Medical director contracts
  - Office space agreements
  - Equipment leases

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Evidence

Short Stay Case

Stark/Anti Kickback Case

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Short –Stay Case:

- General Allegations
  - Provider knowingly and routinely billed services that should have been performed on an outpatient basis as though they were inpatient services:
    - Billed outpatient surgical procedures as inpatient procedures
    - Failed to use observation status
    - Inappropriate in-patient admissions from ED

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Audit 1:

Case management philosophy not clearly defined
- Not clear how case management fits into current structure
- Inadequate staffing – only 1 pre-admit nurse for 50 to 80 admits / day and 1 case manager for 70 to 75 patients
- No process for prescreening patients for severity of illness or intensity of service.
- Not using InterQual criteria to determine patient status
- No tools to monitor resource utilization

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Audit 2:

- "There is no pre-admission review performed prior to the procedure to determine if the patient actually meets clinical criteria for inpatient admission."
- "When post-discharge review is performed, it is usually determined that physician documentation of clinical criteria only supports an outpatient level of care."
- "Many of these cases are inappropriately billed for a DRG level of reimbursement when OPPS reimbursement is indicated."

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Audit 2 Recommendations:

- Implement pre-admission review by case managers
- Provide "intensive education" to admitting physicians on InterQual clinical criteria for inpatient and outpatient interventional procedures
- Establish an organized UR Committee so that patient status can be reviewed prior to discharge
  - UR Committee is a Medicare requirement
  - Recommended adjust claims and reimburse MCR

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Audit 3:

- Patient status order changes are not being processed
- Observation patients are not being reviewed daily by Case Management
- Clinical Documentation Specialists do not look at Observation charts or review for medical necessity
- Patients being admitted to Observation inappropriately when day surgery closes

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Error rates remained at high levels:

- Inadequate resources for Case Management and Utilization Review
  - High turnover, lack of experience, inadequate training.
  - Subsequent audits continued to indicate inadequate utilization review
    - Medicare requires that providers have fully functioning Utilization Review Committees
- Failure to properly prescreen patients for severity of illness and intensity of service
  - InterQual criteria not consistently used
  - Failure to educate physicians and staff on InterQual criteria
    - No policy to discipline consistently offending physicians

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E-mail exchange:

- Question:
  - "These two accounts are admissions into the cath lab and were admitted to 'inpt' status. They do not meet 'inpt' criteria and are 1 day Medicare stays . . . . should I drop the bill and state that they meet criteria so we get the DRG?"
- Response:
  - "One-day stays will be on the target for RAC audits, I would not drop the account."

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Damages and Penalties under the FCA:

- Damages:
  - Singles for 6 Year Period $ 7,608,408
  - Doubles for 6 Year Period $15,216,816
  - Trebles for 6 Year Period $22,825,224
- Penalties:
  - Total 2 Year Universe of Claims: 345
  - Total 6 Year Universe of Claims: 1035
    - 1035 x .85 error rate = 880 claims
- At $5500/Claim: $ 4,840,000
- At $1100/Claim: $ 9,680,000

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Stark / Anti-Kickback Case

- Allegations:
- Provider improperly rewarded physicians for referrals in violation of both the Stark Law and the Anti Kickback Statute?

  Sham medical directorship contracts

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Audit of Personal Services Contract with Physician:

- "Agreement should include maximum and minimum number of monthly hours . . ."
- "The representative time sheets in some cases are not signed, not detailed, and some appear to be copies duplicated from month to month."
- "[the time sheets] do not provide adequate information to document the performance of the duties and responsibilities . . ."

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Audit (cont'd.):

- Time sheets include direct patient care activity, which is on a fee for service basis, and not part of the directorship duties – should be excluded and not counted
  - Physician had included time that he billed under Part B.
- Based on the market survey data (MGMA) for this specialty, the current rate of compensation extrapolated from actual hours worked is beyond FMV range by 369%
- Physician using office space provided for medical directorship at no cost to physician being used by physician to see his own patients

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Email:

- "In 1996 or 1997, Dr. XXX asked administration for an EKG machine …. We had the MAC 15, although it was still working it was in need of repairs and we couldn't find parts for it. My boss said to give the old machine to Dr. XXX and in return he would send his patients for outpatient procedures . . . at that time there were a lot of wheelings and dealings going on to attract medical staff to send patients to [us] . . . . Guilty as charged."

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Email:

- Request
  - " . . . . would you do a letter to Dr. XXX regarding his Sports Medicine Medical Directorship. Tell him since we do not have a program we are going to discontinue this . . . Directorship . . . ."

Response
- "I am afraid that if I send him the letter . . . that I will lose [his] cooperation."

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Memo:

Dr. XXX – Family Practice
Wanted assistance with recruitment
- "I think he spends more time @ XXX !! So Why?"

Dr. XXX – Pediatrics
- "Did he mention what he would like (service) to refer more?"

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Deterring Fraud within Your Organization

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It's all about appropriate incentives !

- Identify multiple performance indicators appropriate for your business, then establish fair and reasonable metrics by which to measure those indicators – base financial incentives on all of those performance indicators
  - Patient experience
  - Health outcome
  - Efficiency of delivery
  - Cost of service
  - Timeliness of payment

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Have a solid compliance plan:

Provide a meaningful way for employees to report fraud
- **Outside employee's chain of command**
- **Addresses all reports**
- **Communicate outcome to complainant**
- **Reward employees for reporting fraud**
- **Punish employees that commit fraud**
- **Periodic testing to ensure it works**

◦ **Must provide for routine and mandatory training**
◦ **All employees, officers included, must be treated equally**
◦ **Must be funded and staffed**
◦ **Conduct routine audits**
◦ **Address recommendations of auditors**

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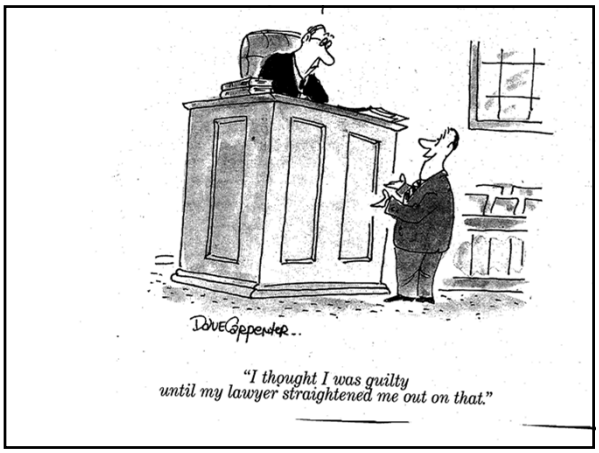

"I thought I was guilty
until my lawyer straightened me out on that."