

MEDICAID COMPLIANCE NEWS

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

Contents

- 3** *Chart:* N.Y. OMIG Keeps Recovering Big Improper Payments
- 3** N.J. OMIG Recovers \$225M in First Year; Fla. Unit Gets New Tools
- 4** *Table:* States With Medicaid Inspectors General
- 5** Mo. MFCU Pulls in \$81 Million in '09; AG Pushes Whistleblower Law
- 6** Owner of Speech Therapy Centers Pleads Guilty to \$1 Million Fraud
- 6** National Dental Firm To Pay \$24 Million in Medicaid Fraud Case
- 7** N.J. DHSS Changes Its Computer System to Prevent Double Billing
- 9** Cathedral Rock Facilities Were Warned With CMPs, Denials
- 11** *News Briefs*

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Nursing Homes Enter Guilty Plea, Pay Civil Settlement in Quality-of-Care Fraud Case

Quality-of-care issues are the reason that five nursing homes in Missouri pleaded guilty to health care fraud, and their owner in Texas has entered into criminal and civil resolutions, federal and state officials said in January. Although cases like this involving both civil and criminal charges are important so that the feds can set an example, it's critical not to let things get out of hand as they did at these facilities, a former prosecutor tells *MCN*.

The Cathedral Rock nursing facilities in and around St. Louis all pleaded guilty in January to Medicaid and Medicare fraud for failing to provide adequate care. They admitted in their plea agreements that (1) staffing was not sufficient to provide adequate care, (2) wound care was not provided, (3) residents often did not receive their medication as prescribed, (4) medical records were falsified and a "charting party" occurred at one facility to fill in bogus information about medication, and (5) the facilities submitted fraudulent claims for services that were not provided or were worthless.

More than 80% of the residents at the facilities were Medicaid or Medicare patients, the criminal information says. So between 2001 and 2005, Medicaid paid about \$57 million to the nursing homes, and Medicare paid about \$19 million.

continued on p. 8

N.Y. OMIG's New Medicaid Fraud Efforts May Hinder Its Ability to Meet Recovery Goals

In fiscal year 2009, New York state exceeded the amount of recovered improper third-party liability payments federally mandated under the Federal-State Health Reform Partnership (F-SHRP). The state also shouldn't have problems meeting recovery goals for FY 2010, which ends Sept. 30. However, according to New York state Medicaid Inspector General Jim Sheehan, the state may have difficulties meeting FY 2011 goals.

Under the F-SHRP — a federal program that sets requirements for Medicaid fraud and abuse recoveries — New York agreed to recover a certain amount of overpayments from Medicaid providers and suppliers every fiscal year through 2011. For example, the recovery target was \$215 million for FY 2008. New York exceeded that target by \$336 million, recovering \$551 million in FY 2008. This was more than was recovered by all states combined in FY 2007 (\$305 million). The recovery target was \$322 million for FY 2009, and is \$429 million for FY 2010 and \$644 million for FY 2011. The state receives recovery payments in various forms, including lump-sum payments, installments and through the withholding of future Medicaid payments to providers.

In a presentation Sheehan made to the state Senate Committee on Investigations and Government Operations Jan. 7, he told the committee that the state has collected \$323 million in FY 2009 recoveries (see chart, p. 3).

continued

In an interview with *MCN*, he says the state should be able to meet the FY 2010 goal, but he is not as certain about FY 2011 recoveries. It will be difficult to collect \$644 million in third-party payments, he says, especially in light of the efforts New York is making to prevent overpayments in the first place. "If I'm right and we get to 2011 [and can't make the recovery goal], we have to go back to CMS" and re-evaluate the target amount, he says. If CMS does not agree with adjusting the targeted amounts and the state fails to meet any of these established goals, it will lose up to \$1.5 billion (up to \$300 million per year) of federal funding for specific designated expenditures.

New York has always been a cutting-edge state when it comes to Medicaid compliance, and some recent and future initiatives continue this trend. For example, beginning Oct. 1, 2009, hospitals and other providers that expect to claim or receive \$500,000 or more in Medicaid funds in any 12-month period must maintain a formal compliance program. The state Office of Medicaid Inspector General (OMIG) required certification that providers have these programs by Dec. 31. The program can be a stand-alone plan or a component of more compre-

hensive compliance activities. Either way, it must apply to billing, payments, medical necessity, quality of care, governance, mandatory reporting, credentialing and other risk areas.

These eight-point compliance programs must include:

- ◆ *a written code of conduct or code of ethics* for employees and others;
- ◆ *designation of an employee vested with responsibility* for its day-to-day operation;
- ◆ *training and education of all affected employees* and persons associated with the provider, including governing-body members;
- ◆ *a mechanism for communicating and reporting compliance issues*, including a method for anonymous and confidential reporting;
- ◆ *disciplinary policies to encourage good-faith participation* in the compliance program;
- ◆ *a system for routine identification of compliance risk areas* specific to the provider type;
- ◆ *systems for responding to compliance issues*, investigating potential compliance problems and correcting problems; implementing procedures, policies and systems to reduce the potential for recurrence; identifying and reporting compliance issues to OMIG; and refunding overpayments; and
- ◆ *a policy of non-intimidation and non-retaliation* for good-faith participation in the compliance program.

Most Providers Have Submitted Certification

Sheehan says that as of Dec. 31, 2009, the "vast majority" of New York providers have complied with the requirements. "There are a few that haven't," and OMIG is "making sure every provider submitted a certification," he adds. For those that don't comply, the "first violation will result in a letter or a visit," explains Sheehan. "We hope it was an oversight." Providers that fail to adopt or certify qualifying compliance programs may be subject to sanctions and penalties, including revocation of their participation in Medicaid. Penalties "will consist of anything up to exclusion from the Medicaid program," he says.

OMIG is in the process of preparing compliance guidance for hospitals and managed care providers that will detail the requirements for compliance programs, but "it is not out yet," says Sheehan. This guidance will also set forth details for providers to conduct their own audits.

"We hope they consider [following] the state Work Plan" when performing their audits, he says. OMIG's Work Plan, released annually, is a road map of all audits and investigations planned for the state fiscal year. It lays

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out for providers all the ways in which they potentially face Medicaid auditors and investigators.

“We will rely on [providers’] audits and will not audit the same areas” as they do, Sheehan tells MCN. He stresses that seeing a provider has conducted “zero audits is not good.”

Other initiatives OMIG has begun recently include surveying auditees, conducting home health audits and focusing on Medicare-Medicaid crossover issues.

Beginning in December 2009, OMIG began surveying all audited providers. According to Sheehan, “we are trying to determine how good a job we are doing with providers.” These audits “make sure for the variables we can control, that people are being treated fairly,” he adds.

OMIG is also planning to focus on crossover issues involving Medicare-Medicaid dual-eligible individuals. “We are looking for situations where we are paying twice,” says Sheehan. For example, a patient who is enrolled in the Medicare Part D prescription drug benefit and has Medicaid may pay in full for a \$50 prescription. If that patient’s plan then turns around and bills Medicaid for the difference or for more than the patient paid, “either one is abuse,” explains Sheehan. “You can’t be paid twice,” he says.

It is a question of matching Medicare and Medicaid data. This is accomplished through a Medi-Medi contractor (CMS’s Medicare-Medicaid Data Match Project). The Medi-Medi project uses program integrity contractors to analyze data from providers’ Medicare and Medicaid

billings, searching for patterns of fraud, waste or abuse. The idea is that providers who commit fraud (or just make errors) are doing so with both programs, not just with one. “Every state has one [Medi-Medi contractor],” Sheehan says. OMIG also obtains data from the third-party liability side (e.g., health plans), he asserts.

Contact Sheehan through OMIG’s Public Information Office at (518) 473-3782.

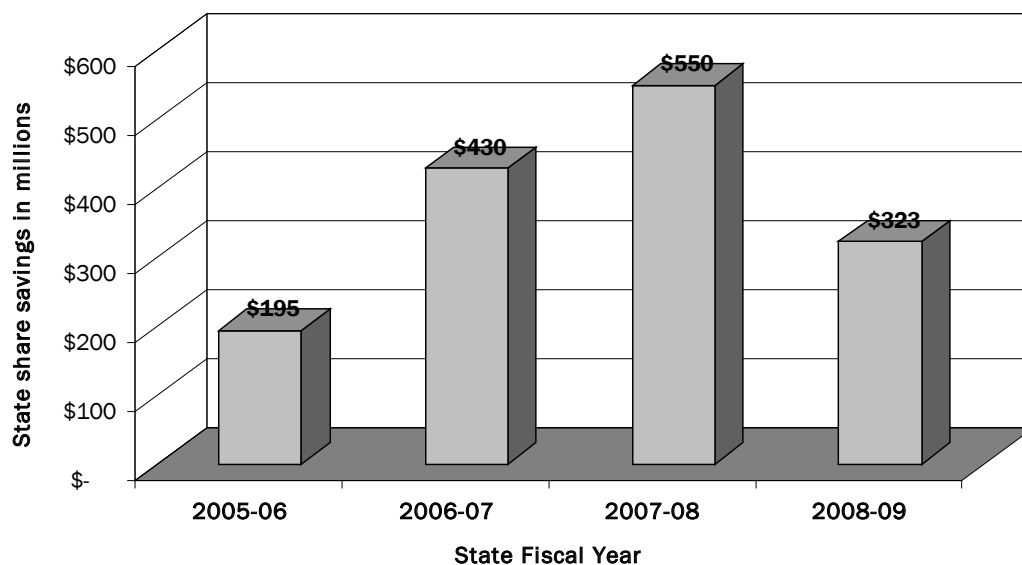
N.J. OMIG Recovers \$225M in First Year; Fla. Unit Gets New Tools

Nearly 20% of the states now have their own offices that are dedicated to fighting Medicaid fraud. And while some offices are just getting started, others are using new tools and authority aimed at prevention.

Texas and New York were the first to create offices of Medicaid inspector general, and some states have followed their models. Although not all of the others have named the units in the same manner, they perform similar functions (see table, p. 4). New OMIGs may be on the horizon as well. Michigan may be the next.

New Jersey is the latest state to add an Office of Medicaid Inspector General. The state modeled its statute and division on New York’s office, says Medicaid Inspector General Mark Anderson. Although it has already been in operation for 10 months, New Jersey’s OMIG is fighting an uphill battle in many ways. For one thing, the office has only 42 employees so far. “Our office was

N.Y. OMIG Keeps Recovering Large Improper Third-Party Liability Payments



SOURCE: New York Office of Medical Inspector General presentation to State Senate Committee on Investigations and Government Operations, Jan. 7, 2010

created by transferring employees from different places," says Anderson. Staff members came from the Division of Medical Assistance and Health Services, according to the OMIG Web site.

"There are 8.5 million people in the state of New Jersey, and there are close to 1 million on Medicaid. And there are countless providers in different [disciplines]. The program is about \$10 billion with federal and state money, so to be able to really scope out the work that's here and do it with 40 folks is tough," Anderson tells MCN. In comparison, the New York state OMIG has about 600 state employees and 150 contractors, according to its Web site.

Despite the initial lack of resources, the New Jersey OMIG says it recovered about \$225 million in its first nine months of operation during 2009. The office is still developing its Work Plan, however. "We're looking at funding at year-end and running reports to see where the biggest bang for our buck is going to be," says Anderson. Most recently, the OMIG told opiate treatment centers in the state to be on notice that the office would seek to recover fraudulent Medicaid billings and false claims (see story, p. 7).

In the meantime, the unit has two goals. "What we want to do is crack down or focus on both provider and recipient fraud. We want to branch out into provider industry groups that heretofore haven't been addressed for Medicaid fraud and abuse" using data-mining trends, looking at what other states are doing and watching what the feds are focusing on, he says.

Anderson says the OMIG will not just be provider focused. "We want to make sure the people who really deserve Medicaid are getting it," he says.

But on the provider side, Anderson says the OMIG will prevent fraud, not play the pay-and-chase game. "We have a unit within our office called the special investigations unit that does background checks on providers to see if they have been federally excluded, to see if they

were truthful on their applications and if they would be prudent Medicaid providers. If we determine that they should not be in our system, we will say no," he says. "So make sure that you come with your books clean and you are truthful on your application — that you have nothing in your past. If you had a scheme in Pennsylvania, Maryland or Delaware, we don't want you here," he asserts.

Anderson says the OMIG gets many tips through its hotline, and that it also is finding fraud through data mining, but that information comes from many other sources. "We get tips from everywhere," he says. People send the OMIG letters describing situations such as that their neighbor with a two-acre home and a Mercedes in the driveway is a Medicaid beneficiary. In some cases, a citizen will inform the OMIG about a provider who is billing for services that the patient didn't receive, he says.

The OMIG also gets calls from legislators and various state agencies that handle licensing and other functions when they see an anomaly. The county welfare offices also are a valuable source "about things they see on the recipient side or interactions with clients about providers or pharmacists," he says. "We've been trying to establish relationships with all of these [sources]."

In Florida, data mining is the most effective tool officials are using to combat Medicaid fraud, says Thomas Arnold, secretary of Florida's Agency for Health Care Administration (AHCA). "We have a data mining capacity here in Florida that allows us to do some tremendous things in the claims we are paying," he tells MCN. This includes "technology that can establish norms for any kind of provider or subset, and this tool will change those norms over any period of time. So if certain providers in a certain part of the state are doing something illegal, the data mining can determine that. It is sophisticated enough to pick up on that change, and we can quickly see what they are doing and take action," he says. "Then we can take a proactive route and put in edits and start audits."

States With Medicaid Inspectors General

Florida	Agency for Health Care Administration, Inspector General
Georgia	Department of Community Health, Office of Inspector General
Illinois	Department of Health Care and Family Services, Office of Inspector General
Kansas	Health Policy Authority, Office of Inspector General
Kentucky	Cabinet for Health and Family Services, Office of Inspector General
New Jersey	Office of Inspector General, Medicaid Inspector General
New Mexico	Human Services Department, Office of Inspector General
New York	Office of Medicaid Inspector General
Texas	Health and Human Services Commission, Office of Inspector General

SOURCE: "The HEAT Is On: Prepare Now for Enhanced Government Enforcement Efforts" by Judy Waltz and Cheryl Wagonhurst of Foley & Lardner, LLP, January 2010.

Arnold's vision is a state without Medicaid fraud. "We don't want any," he says. "That truly is how I envision Florida Medicaid — having little or no Medicaid fraud. Our vision is that we would work to cooperate with the good providers, with the beneficiaries and their advocates, and use whatever tools are available to us through the legislative process in the state or federal government and through an electronic health information exchange to stop fraud in Florida."

Some goals in the strategic plan from the AHCA Inspector General and Bureau of Medicaid Program Integrity are detecting fraud and recouping money, but also learning from those cases and preventing future fraudulent billing. "We want to change the culture of Medicaid so that fraud becomes unacceptable," Arnold says. "We have to demonstrate that we are serious, and we think we're doing that now not just in the provider community, but also in the recipient community... If we get to the point where every provider knows there are consequences, then we have our culture change. But we don't want to establish a situation where we're punishing good providers who are doing good work for beneficiaries, so the culture is not just fighting against fraud, but also supporting good health care," he tells MCN.

South Florida Is a Fraud Target

The stakes in Florida are high. The state legislature has declared south Florida an area of fraud concern, and that region has been on the feds' radar screen for some time, though most of the federal cases involve fraudulent Medicare billing. Medicaid in Florida is an \$18 billion program with 100,000 providers and 2.7 million beneficiaries. "We process nearly a million Medicaid claims every business day," Arnold says. "Our biggest challenge is how to control an environment this big."

To help, state lawmakers last year passed legislation to give AHCA more tools to battle fraud and abuse. "It includes giving our agency, the attorney general's office and the Department of Health more authority to take substantive action against providers." Tools include mandatory termination of provider agreements, taking away facility and professional licenses, and whistleblower provisions so that relators can receive a percentage of any Medicaid recoveries.

"The vast majority of providers out there are doing an excellent job, but a minority has figured out a way to get rich quick, and those are the ones we want to stop," Arnold says.

Contact Anderson through Niki Trunk at (609) 777-4269 and Arnold through Tiffany Vause at vauset@achamyflorida.com. Visit www.state.nj.us/njomig. ✧

Mo. MFCU Pulls in \$81 Million in '09; AG Pushes Use of Whistleblower Law

Missouri's Medicaid Fraud Control Unit had a record year of fraud collections due in part to two nationwide settlements with major pharmaceutical companies, but also to criminal convictions and civil settlements the MFCU handled, Missouri Attorney General Chris Koster (D) tells MCN. Although the state cashed in on those lucrative settlements with drug makers, Koster says the MFCU will concentrate on smaller cases within the state for the immediate future.

The MFCU obtained \$81.6 million in calendar year 2009, more than double the previous record of \$33.6 million in 2008, Koster's office said Dec. 30. Civil settlements agreed to by Warrick Pharmaceuticals and Pfizer Inc. contributed \$31 million and \$22 million, respectively, to the total. In addition, the MFCU settled 13 civil Medicaid cases and obtained a summary judgment on one suit. The unit also obtained three criminal convictions at the state level and helped the U.S. attorney's office with five federal criminal convictions. These cases were "straight-ahead fraudulent billing situations," he tells MCN.

Mo. AG's Office Targets Smaller Cases

Koster says his office will not be relying on the big national cases to recoup lost Missouri Medicaid dollars. "We need to develop the smaller cases here in Missouri that are usually in the \$50,000 to \$150,000 range where individual businesses are billing for services that are not provided," he says, and explains that the unit will not be concentrating on one type of provider. "We don't want to limit it to certain providers. We're trying to send a message to all disciplines that this area is being monitored. A small percentage of fraudulent billings takes an awful lot of money."

The MFCU's hotline is an important tool for receiving information about potential Medicaid fraud. Koster says tips also come from state agencies such as the Missouri Department of Social Services. "They do baseline analyses of costs to the Medicaid program, and sometimes when they find anomalies, they will forward them to us."

Koster's office is also trying to spread the word about the state's whistleblower statute, which was enacted in 2007 and offers relators 10% of the Medicaid recovery. "We're increasingly trying to develop a sense in the community that if you work for one of the 35,000 [health care] companies — and that's a lot of employees — that you pick up a phone and call us to explain the situation to us," he says. "There are a number of [whistleblower cases] in the pipeline, but we have yet to resolve one. We are engaging in a campaign to try to raise awareness."

Contact Nanci Gonder in the attorney general's office at nanci.gonder@ago.mo.gov. ✧

Owner of Speech Therapy Centers Pleads Guilty to \$1 Million Fraud

The owner of a chain of psychological and speech therapy centers in North Carolina pleaded guilty on Jan. 15 to defrauding Medicaid and TRICARE out of more than \$1 million over three years, according to the U.S. Attorney's Office for the Eastern District of North Carolina.

Federal officials allege in a criminal information that Sandra Elliot, owner of Learning Links Educational Network Services Center, Inc., billed for services that were not provided, billed under the provider number of practitioners who did not work for Learning Links, and billed for services provided by unlicensed personnel, among other things.

Learning Links first opened in Fayetteville, N.C., in 2006 to treat children with developmental issues or anger-management problems. The company primarily billed Medicaid and TRICARE (the benefit program for members of the military and their dependents). "Through [the] routine billing to these programs, Elliot expanded the Learning Links operation to four locations in Fayetteville and Dunn, and was planning to open other facilities," the feds say.

Federal officials raided the Learning Links offices in 2009 and seized all medical records and e-mail correspondence, the U.S. attorney's office says. Investigators learned that:

- ◆ Some children who were alleged to have received services were not even in the state on the billed date;
- ◆ Some claims were for services to children several months after stopping treatment at Learning Links;

◆ Practitioners who were no longer working for the centers were still being listed on Learning Links's billing submissions as the provider of services; and

◆ Some of the individuals providing services did not possess the requisite licenses for the billed services.

The feds say the exact loss to the government is still being calculated, but Elliot and the U.S. attorney's office estimate that it exceeds \$1 million. Elliot faces a maximum 10-year prison sentence, plus three years of supervised release and a fine of up to \$250,000. As part of her plea agreement, she has agreed to forfeit two cars, a recreational vehicle and more than \$200,000. An attorney representing her could not be reached for comment.

Visit www.justice.gov/usao/nce. ◆

National Dental Firm Agrees to Pay \$24 Million in Medicaid Fraud Case

The latest — and biggest — settlement with a chain of dentists is a reminder that Medicaid investigators are monitoring billings from dental practices, and that quality-of-care issues also extend to providers other than hospitals and long-term care facilities.

FORBA Holdings LLC, a Nashville-based management company that provides administrative services to a chain of 69 dental clinics nationwide, will pay a total of \$24 million to settle allegations that it filed false Medicaid claims, the Department of Justice said Jan. 20. The federal government will receive \$14.2 million, and 21 participating states will share \$9.7 million.

The company serves Medicaid-eligible children exclusively, court documents say. Dentists who work for the chain, which operates under the name Small Smiles

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Centers, allegedly performed medically unnecessary services on their minor patients, the feds say. Some of the services were “performed in a manner that failed to meet professionally-recognized standards of care” for such procedures as pulpotomies (i.e., baby root canals), placement of crowns, administration of anesthesia, extractions and providing fillings or sealants.

The government’s case stems from three whistleblower lawsuits, the feds say. The whistleblowers will share \$2.4 million from the federal government’s part of the settlement.

In one complaint, a former Small Smiles employee-turned-whistleblower alleges that she was trained by FORBA employees on a policy known as “conversion,” through which they converted their routine patients into “patients receiving procedures beyond routine check-ups and cleanings.”

After a routine checkup with a child, the Small Smiles staff would consult with the parents and allegedly pressure them to sign consent forms for immediate additional procedures, the complaint says. The procedures were done the same day because Small Smiles employees thought (1) the patients and parents would never return for the additional procedures, and (2) the parents might seek out second opinions for their children.

FORBA Allegedly Set Billing Quotas

The complaint further alleges that FORBA set billing quotas for each facility. One clinic allegedly had a quota of \$20,000 in billings per day. The company also allegedly offered monetary bonuses for employees to encourage them to “convert” the patients, the complaint says.

In a statement on the company’s Web site, FORBA Chairman and CEO Michael Lindley says the company settled to “avoid the delay, uncertainty, inconvenience and expense of litigation.” FORBA did not admit liability, he adds. “The settlement validates changes we made to improve training initiatives for our dentists and caregivers, strengthen our compliance and internal auditing processes and enhance the care that we provide to children who visit our centers every day,” he says.

As part of the settlement, FORBA has entered into a five-year corporate integrity agreement (CIA) with the HHS Office of Inspector General. The CIA specifies that FORBA must hire external reviewers to monitor its quality of care and reimbursement processes. And the chief dental officer must develop and implement policies and procedures to ensure that the clinics provide services consistent with professionally recognized standards of care. The company also has agreed to cooperate with the government’s ongoing investigation of individual dentists.

This case is similar to one in which The Medicaid Dental Center, a North Carolina chain of clinics, paid \$10

million in 2008 to settle allegations that it performed unnecessary, invasive and “sometimes painful” procedures on indigent children (*MCN 5/08, p. 2*).

That case was settled before a complaint could be filed in court. An attorney representing this company told *MCN* that the case involved areas for which there was no standard for billing at the time. Medicaid said in 2004 that no more than six crowns should be placed in a patient in one day, while there was no limit before, he pointed out.

Medicaid investigations of other individual dentists have cropped up over the years:

◆ *In the most recent case, a Kentucky dentist was sentenced to five years in prison on Jan. 4 for Medicaid fraud and drug trafficking.* He pleaded guilty and was ordered to pay \$4,900 in restitution to Kentucky Medicaid. The state alleges that from March 1988 to September 2004, he billed for dental extractions that either were not performed or weren’t necessary.

◆ *A Missouri dentist was charged with 13 counts of Medicaid fraud in November 2008 (MCN 12/08, p. 9).* The state said he submitted false Medicaid claims from November 2005 to June 2006 for services not performed on pediatric patients, including X-rays, root canals, resin-based composite restorations and amalgam restorations.

◆ *A New Mexico dentist received a deferred sentence in May 2009 after she pleaded guilty to three counts of Medicaid fraud (MCN 6/09, p. 5).* She allegedly submitted fraudulent billings from 2003 through 2005. As part of her sentence, she was ordered to reimburse Medicaid \$17,522 and was banned from participating in Medicaid for five years. Her practice was permanently excluded from the program.

Visit www.justice.gov; click on “Briefing Room.” ✦

N.J. DHSS Changes Its Computer System to Prevent Double Billing

Seven methadone clinics in New Jersey have been charged with improperly billing Medicaid \$3.5 million from 2007 to 2009. They face up to \$51.5 million in penalties under the state false claims act, and their alleged actions have forced the state to revamp its computer systems to prevent double and incorrect billing. This should be a warning to other Medicaid providers to follow the Current Procedural Terminology (CPT) coding system for identifying medical procedures and directing proper billing for different services.

According to the state Office of the Medicaid Inspector General (OMIG), after a spot-check by the state Department of Health and Senior Services, OMIG investigated the clinics — Khaleidoscope Health Center, Urban Treatment Center, the Lennard Clinic (two sites),

New Street Treatment Center, HabitOpCo and Suburban Treatment Center. DHSS performs random-sample site visits to providers on a spot-check basis.

OMIG alleged on Dec. 29 that it found:

- ◆ multiple billings of one code for lab tests contrary to current CPT billing code procedures;
- ◆ billing for CPT codes that are not allowed for the types of tests performed; and
- ◆ billing for tests that were not conducted because the facility did not have the required equipment.

OMIG Alleges \$3.5M in Improper Billing

These three types of billing schemes allegedly resulted in improper Medicaid billing of \$3,508,070.20, according to OMIG. For example, Urban Treatment Center allegedly fraudulently charged Medicaid more than \$900,000.

Based on a \$1,000 penalty per claim under the false claims act, OMIG said it is attempting to recover from Urban Treatment Center \$11.6 million and a total of \$51,544,068 from all seven clinics. This is based on alleged billing by the clinics of "15,000, 25,000, even 73,000 improper claims for one CPT code in less than a two-year period," said OMIG. "The conduct of these centers demonstrated a complete lack of responsibility over precious Medicaid dollars," said New Jersey Medicaid Inspector General Mark Anderson.

The clinics had 60 days to respond to the charges. At *MCN* press time, three clinics had not replied to requests for comments on whether they had responded to the charges. Khaliedoscope Health Center and The Lennard Clinic declined to comment and referred *MCN* to their attorneys, who failed to respond to requests for comments.

In addition to paying penalties, the clinics will also have to file corrective action plans with OMIG outlining the steps and safeguards they will take to assure that future billings are accurate and use the appropriate billing procedure codes.

Moreover, according to OMIG, the state has changed its computer system to prevent treatment centers from being able to double bill for the same test and to limit the number of times certain CPT codes can be used. "It is just as important, if not more important, to implement changes to the current system so we are not always chasing money after it goes out the door," said Anderson. The state is not only responsible for recovering money, "but [also for] prevention," he added.

Go to www.state.nj.us/njomig/documents/Methadone%20Clinic%2012.09.pdf. ◆

Nursing-Home Quality Case Settled

continued from p. 1

The majority owner of the Texas company that runs the facilities, C. Kent Harrington, entered into a two-year criminal deferred prosecution agreement. Harrington is charged in a criminal complaint with defrauding Medicaid and Medicare by submitting false statements and claims for "grossly deficient care." If he implements a rigorous compliance program at the facilities and ensures that residents receive quality care, the complaint will be dismissed on Jan. 7, 2012, says the U.S. Attorney's Office for the Eastern District of Missouri. The facilities and Harrington face criminal fines and penalties totaling \$1 million.

In addition, the parties have entered a civil settlement and will pay \$628,000 to resolve allegations that they violated the False Claims Act by submitting claims for care that was not provided to the residents. They have also entered into a five-year corporate integrity agreement (CIA) with the HHS Office of Inspector General that includes "extensive" quality-of-care provisions, the feds say. As part of the CIA, a monitor will assess Cathedral Rock's quality control systems at all the facilities the company operates, including those that are not in Missouri.

The civil case was originated by two former employees of one of the facilities. They will receive \$94,200 as whistleblowers.

Facilities Were Pressured for More Patients

The feds allege in the civil case that residents suffered from malnutrition, dehydration, preventable pressure sores and preventable side effects from not receiving their medications. In extreme cases, the feds say that some residents had legs or feet amputated because pressure sores formed and were left untreated. Sometimes the sores became infested with maggots, the feds add.

Some of the facilities had issues with residents wandering away until the staff noticed several hours later that they were gone. Residents also tried escaping through windows. One patient ended up on the roof. Another fell out of a third-story window and died from the fall, the feds say.

Despite the fact that patients were suffering such injuries, Cathedral Rock was pushing administrators to take on more residents, court documents say. A December 2001 corporate newsletter said "to retain just one resident that one employee may consider inappropriate, it would mean another \$835,000 per year in income. When you consider that we have asked each administrator to increase his/her census by six residents next year, you can see the impact that each and every resident has. The combined total of \$5 million makes the difference be-

tween profitability and non-profitability, or, put another way, being able to pay bonuses or no bonuses.”

Facility administrators tried to show that they had enough clinical staff by counting employees, such as medical records personnel, in with the nursing staff. In answering complaints from residents about staff shortages, state officials found that there was only one staff member for 31 residents at one of the facilities.

And good employees were apparently hard to come by. One nurse e-mailed company executives saying, “The employees there are the worst I have seen in years. I believe, out of the entire nursing staff, we only have two good nurses,” the criminal information says.

“On some occasions between 2001 and 2005, the lack of nursing staff at the nursing facilities directly caused and contributed to care at the nursing facilities that failed to meet professionally recognized standards of health care and that was so deficient, inadequate and substandard as to constitute worthless services,” the feds say.

The nursing homes were given many chances to fix the problems. Officials from the Missouri Department of Health and Senior Services would visit to ensure that state and federal laws were being followed. The officials would find deficiencies and report them to CMS with recommendations for fines or a stop on federal payments (see box, this page). In many cases, state surveyors returned to find the same or other deficiencies. Sometimes the fines were reduced for one reason or another.

An attorney representing Cathedral Rock and Harrington refused to comment on the case to *MCN's* sister publication, *Report on Medicare Compliance*. A spokesperson for Cathedral Rock could not be reached for comment.

Don't Let Inmates Run Asylum

“It shouldn't get to the point where it takes civil and criminal resolutions to protect patients,” David Hoffman, a former federal prosecutor who helped pioneer the use of the False Claims Act for alleged substandard care, tells

Cathedral Rock Facilities Were Warned With CMPs, Denials

The Cathedral Rock nursing homes were warned about their deficiencies by federal and state officials through surveys, letters, civil monetary penalties (CMPs) and denial of Medicaid and Medicare payments, according to the criminal information filed against them (see story, p. 1). Here are examples of fines against and warnings to two of the facilities:

◆ **SpringPlace Care Center** in St. Louis was visited by state officials on July 5, 2001. They found that the nursing home was not in compliance with the Conditions of Participation in Medicare and Medicaid. In a revisit on July 30, officials found that SpringPlace still was not in compliance. They recommended a \$10,000 CMP. CMS imposed the CMP, plus another \$200 per day from July 30 through Oct. 2, 2001. SpringPlace paid the \$23,000 in March 2002.

◆ Officials began denying payments for SpringPlace on July 27, 2001. CMS recommended terminations of its provider agreement effective Nov. 19, 2001.

◆ On May 15, 2003, July 9, 2003, and July 25, 2003, state officials again found that SpringPlace was not in compliance with the Conditions of Participation. The state again recommended a \$10,000 CMP and denial of payments. The state also recommended termination of the provider agreement to be effective Nov. 15, 2003. CMS imposed the \$10,000 CMP, but reduced it by 35% because SpringPlace waived its right to a hearing.

◆ Surveys on Sept. 17, 2003, and Feb. 17, 2004, found that SpringPlace was not in compliance with the Conditions of Participation. Another visit on March 31, 2004, found that the facility “failed to provide sufficient staff to provide care and supervision for the residents during the night shift.” CMS imposed denial of payments effective April 4, 2004, and again recommended termination of SpringPlace's provider agreement.

◆ SpringPlace voluntarily terminated its participation in Medicare and Medicaid on May 30, 2004.

◆ **McLaran Care Center** in St. Louis was found to be out of compliance with the Conditions of Participation on March 1, 2002, and the state recommended denial of payments for new Medicaid and Medicare admissions.

◆ In December 2002 and March 2003, officials found that McLaran was still out of compliance and imposed \$10,000-per-instance CMPs.

◆ Officials visited in March and April 2004 and found that McLaran still wasn't in compliance. CMS said in May 2004 that it would continue denial of payments already put in place in January of that year.

◆ After a survey conducted because of a complaint in July 2004, CMS imposed a \$4,050-per-day CMP from July 5 through July 21, 2004, for a \$68,850 total CMP.

Read more about the case at www.justice.gov/usao/moe.

MCN. In the Cathedral Rock case, there were "civil monetary payments that were imposed and then reduced.... There is the notion that money penalties are somehow going to convince some providers to do the right thing. [For] any provider that puts profits over care, at the end of the day, [a \$10,000 CMP] is not going to be an effective remedy. So perhaps regulators need to be more aggressive with other remedies out there."

Hoffman says facilities should get one chance after a survey that finds deficiencies. The facility should adopt a corrective action plan and stick to it to fix things. If not, its contract with Medicaid and Medicare should be terminated. "While it is important to have these prosecutions, can you imagine the suffering that residents went through over this significant period of time? It's just not acceptable conduct. I think these cases are important to send a message, but I think it is a sad day that they get this far."

Quality of care at nursing facilities appears in the OIG 2010 Work Plan, through assessments and care planning. "If you do a poor [assessment or care plan], you're already behind the eight ball," says Hoffman, president of David Hoffman & Associates, a consulting firm in Philadelphia. Another issue to watch, he says, is whether you have enough staff to meet patients' needs and whether your staff has the skills needed. "If you don't do it right from the beginning, you're already placing residents at risk."

"From a systemic point, if you're doing assessments and noting changes, then you're meeting their needs, and if not, you need to seek out expertise,"

Hoffman continues. Facilities, including hospitals, need to understand the capabilities of their staff. Some questions they should ask are: What kind of capacity do we have in this building? What kind of knowledge base do we have? Do we have competent staff? "If you're evaluating competencies and you find that there are deficiencies, you must ensure that you can perform basic nursing tasks," he says.

There is a difference between not having enough staff and not having good staff, Hoffman points out. At Cathedral Rock, there was the recognition that they had problem staff members, according to court documents. "So how do we fix that?" Hoffman asks. "Remove them or try to train and educate them....Once you reach the point where it is accepted, then the whole culture of the place is gone, and you have the inmates running the asylum," he says.

To avoid a Cathedral Rock-type situation, facilities should integrate quality into their compliance programs. "If there is a robust compliance program, I would hope that employees know that there are 'charting parties' going on and that they need to be reported. Falsification of documents will clearly impact quality" because patients aren't receiving the services or medications that are put on the charts, Hoffman says. "Once CMPs are imposed, it's a compliance issue. Ensure that you're fixing [the deficiencies] and that the compliance officer is on top of it."

Contact Hoffman at (215) 854-6357. Read more about the case at www.justice.gov/usao/moe. ♦

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NEWS BRIEFS

◆ **The HHS budget submitted as part of President Obama's fiscal year 2011 budget contains significant funding increases to deter health care fraud, with a \$1.7 billion total for HHS fraud-fighting efforts that includes \$47.7 million for Medicaid.**

"The budget includes \$561 million in discretionary resources, an increase of \$250 million, to strengthen Medicare and Medicaid program integrity activities, with particular emphasis on fighting health care fraud in the field, increasing Medicaid audits, and strengthening program oversight while reducing costs," HHS says about the funding. The jump in discretionary funds will go to the Health Care Fraud and Abuse Control program, part of multi-year fraud-fighting efforts that have been included in the budget for the past two years, budget documents explain. HCFAC priorities include "identifying and recouping excessive payments, pinpointing potential weaknesses in program integrity oversight, and establishing new processes and safeguards to correct programmatic vulnerabilities," the agency says. HHS explains that the budget also includes new proposals to save \$14.7 billion over 10 years. And there is a \$60.2 million increase to fight Medicare and Medicaid fraud via the HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team, also known as HEAT, which officials hope to expand to 13 new metropolitan areas for a total of 20 cities. Read more about the HHS budget at www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf.

◆ **Sen. Chuck Grassley (R-Iowa) introduced a bill Jan. 28 that will attempt to deter fraud, waste and abuse in Medicaid and other federal health care programs.**

If enacted, the Strengthening Program Integrity and Accountability in Health Care Act (S2774) also would prohibit Medicaid payments for unapproved drugs, expand the Recovery Audit Contractor program to Medicaid, strengthen the reporting requirements to the Medicaid Integrity Program (requiring contractors to provide HHS and its Office of Inspector General with the number and amount of overpayments recovered, plus the number of fraud referrals, etc.). The bill also would (1) deter fraud through enhanced screening to help keep fraudulent providers out, (2) give the government more time to evaluate the legitimacy of providers before payment is required, (3) strengthen the feds' ability to detect fraud with better disclosure requirements, (4) enhance coordination among federal

agencies, and (5) improve enforcement capabilities by expanding the range of activity subject to penalties and toughening existing penalties. To read a full summary of the bill, visit <http://finance.senate.gov> and click on "Press Releases."

◆ **The former owners of City of Angels Medical Center have agreed to a \$10 million consent judgment with the government to resolve a scheme to defraud Medicaid and Medicare,** the Department of Justice said Jan. 25. The state of California also joined the consent judgment for recoveries to Medi-Cal, California's Medicaid program. The agreement resolves a civil suit filed against Robert Bourseau and Rudra Sabaratnam, which alleged that they directed a scheme in which employees at homeless shelters recruited homeless people to go to the hospital regardless of whether they needed or requested medical treatment. The facility allegedly would then bill the federal programs for medical services that were not necessary in violation of the False Claims Act, the feds say. The government also alleged that payments to the recruiters constituted kickbacks. In addition to this settlement, Bourseau and Sabaratnam both have pleaded guilty to criminal charges for violating the anti-kickback statute and are awaiting sentencing. Visit www.justice.gov.

◆ **The Texas Health and Human Services Commission's Office of Inspector General reported "a record year" of recoveries from programs including Medicaid in its fiscal year 2009 Annual Report, released Jan. 5.** The state imposed sanctions on providers totaling \$31.2 million for the fiscal year, and civil monetary penalties charged also totaled \$31.2 million. Utilization review of hospitals brought in \$22.1 million, and review of nursing homes recovered \$8 million, the state reports. More than 560 Medicaid integrity cases were opened during the fiscal year, 270 cases were referred to the state attorney general and 175 were referred to other entities. To read the report, visit <https://oig.hhsc.state.tx.us/> and click on "Reports and Information."

◆ **HHS Sec. Kathleen Sebelius, Attorney General Eric Holder, law enforcement personnel and health care experts discussed Medicaid fraud control and other issues Jan. 28 at the National Summit on Health Care Fraud in Bethesda, Md.** The summit included a panel discussion with HHS and DOJ officials about methods used to prevent and crack down on fraudulent activity in federal health care

NEWS BRIEFS (continued)

programs. Other workgroups focused on (1) the use of technology to detect improper payments, (2) the role of states in preventing health care fraud, (3) development of effective prevention policies, (4) effective law enforcement strategies, and (5) measuring health care fraud, assessing recoveries and determining resource needs. Summaries of the discussions will be compiled into a publicly available report. Visit www.healthcarefraudsummit.com.

◆ **An Athens, Ga., psychologist was given a two-year prison sentence for defrauding Medicaid out of more than \$500,000**, the U.S. Attorney's Office for the Northern District of Georgia said Jan. 28. Paul Mangum also will pay \$558,000 in restitution. He pleaded guilty to health care fraud in September 2009. The feds say Mangum submitted thousands of fraudulent claims to Medicaid for psychological therapy sessions that never took place. He would bill for patients under the age of 21 who he had previously treated, but who had stopped coming, sometimes years before. "For example, Mangum saw one child once a week for only a few months, but then submitted over 100 fraudulent claims for the patient over a period of more than five years, receiving thousands of dollars in Medicaid payments for therapy sessions he never performed," the feds say. Mangum also submitted claims for the younger sibling of a patient even though he never treated the sibling, the feds add. He was keeping two separate appointment books (one for legitimate services and one for fraudulent billings) and fabricated patient records, the feds allege. Visit www.justice.gov/usao/gan.

◆ **The co-owner of a now-defunct mental health clinic in Trenton, N.J., pleaded guilty Jan. 27 to Medicaid fraud**, according to the New Jersey Attorney General's Office. Osvaldo Morales co-owned the Chambers Mental Health Clinic LLC. The state alleges that Morales and his co-defendants billed Medicaid using the provider number of a physician who did not provide the services, and billed for longer counseling sessions than what was provided. He and his co-defendants were charged in a November 2007 indictment. Two of the co-defendants have pleaded guilty, and the case against another is pending. One of the other co-owners is barred from participating in Medicaid, the state says. Visit www.nj.gov/oag.

◆ **Two people were convicted in December by a federal jury in Idaho of defrauding Medicaid of more than \$250,000**, according to the U.S.

Attorney's Office for the District of Idaho. Ronald Hamilton was the owner of Teton Family Services, a company with several clinics that offered "partial care for children," the feds say. Vanessa Cattanea was the treatment director for the company. The feds say that they knowingly and fraudulently billed Medicaid for services provided away from the clinics (including trips to a national park), and for services provided by unlicensed staff. After a nine-day trial, the jury found Hamilton guilty of 55 out of 72 counts and Cattanea guilty of 76 out of 84 counts. Both face a maximum sentence of 10 years in prison on each count. An attorney representing Cattanea declined to comment. Hamilton's attorney said he will be appealing the case and that Hamilton denies that there was an intent to defraud. Visit www.justice.gov/usao/id.

◆ **Republicans in New York state's Senate have formed a task force on Medicaid fraud**, Senate Republican Leader Dean Skelos said Feb. 2. The group will hold hearings in February in Albany and Nassau County and will then issue recommendations before the state's April 1 budget deadline. "This task force will investigate whether or not the fraud prevention system is working at an optimal level and subsequently, develop a realistic solution to protect our taxpayers and the people who truly need Medicaid to pay for health care," state Senator Kemp Hannon said in a prepared statement about the task force. Skelos says a law passed in 2006 that created the state's Office of Medicaid Inspector General and gave counties incentives to become active in the Medicaid fraud fight, among other things, has not had as much of an impact as lawmakers expected. Skelos sponsored the law. "[This] task force will find out why and recommend ways to improve fraud prevention, prosecution and recovery," he says. County officials say the state inhibits their efforts at stopping Medicaid fraud at the local level, the Republicans' statement says. "In fact, the 2009-10 state budget approved by the Governor and legislative Democrats eliminated the eligibility requirements for face-to-face interviews, finger-imaging and asset tests for applicants for Medicaid that are conducted by counties," it adds. Read more at www.nysenate.gov/senator/dean-g-skelos.

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