Medicare Fraud Alert Misconceptions: The Path to Prison?

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What causes Medicare fraud? From where does it originate? Certainly there are obvious cases of greed – physicians billing for fictitious patients, procedures never performed or the rendering of unnecessary medical treatments. But is there more to Medicare fraud than the obvious? Do widely held misconceptions put the normal practitioner at risk?

A recent article in JAMA (Wynia, Matthew K., et al., Vol. 238 No 14, April 12, 2000) reports that 72% of all physicians in the past year, at least once, either exaggerated the severity of a patient's condition, changed a patient's billing diagnosis or reported signs or symptoms that a patient did not have, to help the patient secure coverage for needed care. Of those admitting to manipulating the system, a staggering 54% responded that they do so more now than they did five years ago.

Of significant interest is the finding that physicians who worry about prosecution for fraud were not less likely to admit manipulating reimbursement rules. Not surprisingly, the 28.5% of physicians who responded that they "gamed the system," did so based upon their belief that it was necessary to provide high-quality care.

Gaming the System

While physicians admit to manipulating the system, only 15% agreed that doing so is ethical if done for their patients' benefit. The obvious conclusion is that even though physicians know that manipulating the system is unethical, many still do so – often without personal gain, but merely to benefit their patients.

While "gaming the system may be viewed as a charitable and humane gesture, necessary to circumvent arbitrary and even cruel decisions of third party payors (even if it technically cheats the payor), government prosecutors take a very different view. Indeed, recent events make it clear that these infractions (even if altruistic) can result in serious problems for the well-meaning physician.

There is a severe misconception among physicians that Medicare fraud is what someone else does – that it does not include what the physician view as kind gestures for deserving patients, or doctors ignorant of the requirements. The truth is that all wee-meaning practitioners who bend the rules are placing their careers, indeed their very freedom, at risk.

Janet Reno and the United States Department of Justice declared Medicare fraud to be "the crime of the nineties," second only to violent crime. [1] To combat this "scourge" the Federal Government has invested more assets to identify and prosecute errant physicians and Medicare providers than it allocates to combat organized crime, the war on drugs, and every other form of white-collar crime!

The Healthcare Portability Act of 1996 authorized several hundred million dollars in new funding exclusively designated for the investigation of allegations of Medicare Fraud. Expenditures increase yearly through 2003.

These funds are not being used to simply audit providers and seek reimbursement where the audit demonstrates improper billing. These funds are being used by the FBI to conduct criminal investigations which are then referred to the United States Attorney for prosecution.

Recent efforts by the Federal Government provide a mere peek into the extent of the planned assault.

[1] U.S. Department of Justice, Health Care Fraud Report: Fiscal Years 1995-1996, Washington D.C. ; U.S. Dept. of Justice; 1996 & Office of Public Affairs; June 16, 1995, Washington D.C., U.S. Dept. of Justice.

Since 1995 the rate of conviction for Medicare fraud has increased more than 400%.[2]

Over a brief five year period:

- The number of criminal cases brought for Medicare fraud has increased more than 300%.[3]
- The number of civil actions brought for Medicare fraud has increased more than 250%.[4]

In fact, in just 1998 alone, the federal government's Medicare fraud efforts have recovered almost 500 million dollars[5] and at the last calculation, there are more than 3,500 actions presently pending for Medicare fraud.[6]

Misconception 1

The Government's efforts are limited to the classic "Medicare mills" that submit claims for fictitious patients or for providing durable medical equipment which was never indicated or provided.

An examination of the pending criminal and civil actions involve individual practitioners and their interpretations of the esoteric CPT codes, modifiers, bundling and unbundling of fees; and other purported billing infractions, in a reimbursement system encumbered by regulations and interpretations that are now arguably as complex as the Internal Revenue Code.

Broad definitions of fraud have provided prosecutors with a net wide enough to trap many well-meaning physicians who fail to interpret the Medicare guidelines according to the latest interpretation offered by the Government. Or who fail to provide medical care as the Government determines, retrospectively, it should have been provided.

Indeed, the United States Attorney's office has announced that not only billing infractions, but also the provision of what the government determines to be poor quality of care, will constitute fraud. "No longer will be involved primarily with sophisticated frauds on complex payment schemes (billing for services not rendered, up coding of services, providing unnecessary services). Law enforcement's role will become the policing of deliberate denials or limitation of necessary services and provision of poor quality services."[7]

Misconception 2

Fraud investigations are limited to only "bad doctors" who purposefully defraud the Medicare system.

No longer does the Government limit its activities to those who intentionally defraud the system. While the False Claims Act prohibits only the "knowing" submissions of false claims, the definition of "knowing" is very different from that found in Webster's Dictionary. "Knowing" is redefined to include physicians who act in "deliberate ignorance" or with "reckless disregard." Therefore, errors not detected through vigilant supervision of the billing department, or delegation of billing functions to a third party, can readily fall within the definition of "knowing" if services are not correctly documented, coded, and billed.

Penalties

Failure to dot all "I's" and cross all "T's" can be extraordinarily costly. Lack of vigilance exacts an awful price. Under the False Claims Act, a physician who violates the Act can be assessed penalties equal to three times the original amount of the claim along with mandatory penalties of $5,000 to $10,000 per claim. A single five-dollar overcharge can result in a fine in excess of $10,000. If that coverage is a result of miscoding, chances are the error has been repeated in every case where the code has been misused. If the code is misused a hundred times, a $500 overcharge can result in penalties in excess of a million dollars!

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[2] White House Press Release, March 2000.

[3] U.S. Dept. of Justice, Health Care Fraud Report: Fiscal Years 1995-1996, Washington D.C., Dept. of Justice, 1996 Health & Human Services and Department of Justice, Health Care Fraud and Abuse Control Program Annual Report for FY 1998, Washington D.C. Dept. of Health and Human Services and Depart. of Justice, 1999.

[4] U.S. Dept. of Justice, Health Care Fraud Report: Fiscal Years 1995-1996, Washington D.C.; U.S. Dept. of Justice, 1996 & Department of Health and Human Services and Department of Justice, Health Care Fraud and Abuse Control Program Annual Report for FY 1998, Washington D.C., Dept. of Health and Human Services and Dept. of Justice, 1999.

[5] Department of Health and Human Services and Department of Justice, Health Care Fraud and Abuse Control Program Annual Report for FY 1998, Washington D.C. Dept. of Health and Human Services and Dept. of Justice, 1999.

[6] Department of Health and Human Services and Department of Justice, Health Care Fraud and Abuse Control Program Annual Report for FY 1998, Washington D.C., Dept. of Health and Human Services and Dept. of Justice, 1999.

[7] A qui tam is a suit brought by an individual on behalf of the Government.

Misconception 3

Physicians' exposure begins with a Medicare audit.

The Government is not the only entity investigating physicians' practices. The Government is aggressively enlisting every patient in its vigilante campaign. The Internet, e-mail, director solicitation, and even personal training sessions, are being utilized to recruit informers and whistleblowers. And the Government is not relying solely on the expectation that patients will be "good citizens." Bounty awards are being offered to those patients who identify incidents of "fraud." If a patient reports a misbilling to the Government, which is subsequently found to be "fraud" the patient gets a $1,000 reward for each incident of "fraud" reported. The odds are far better than the lottery, and there is no cost of entry to play the "game."

Another ready source of information to the Government is associates and employees. These whistleblowers can receive as much as 25% of any recovery obtained by the Government by providing the information the Government needs to initiate its investigation. Individuals have received hundreds of thousands of dollars by bringing these qui tam actions against their employers and former employers.[8] Frighteningly, over a four-year period, there has been a 1200% increase in whistleblower lawsuits. A disgruntled employee facing the prospect of a huge windfall is, without a doubt, a lurking danger in any physician's office.

Other Investigative Devices

The Federal Government is now actively using State Medical Boards as a part of its clandestine investigative arsenal. The US Attorney and the FBI are now cloaking their involvement in Medicare fraud investigation by simply asking licensing boards, to obtain medical records and statements under oath and to conduct informal interviews and investigative hearings to determine whether a fraud case may exist. A seemingly routing inquiry by the Board of Medical Examiners may, in fact, be part of very serious criminal investigation, orchestrated by the federal Government. Unwary physicians may easily be lulled into providing damaging testimony that can be used against them at a later time in furtherance of a criminal prosecution. Fifth Amendment protections against self-incrimination can be unwittingly waived in an effort to cooperate with a seemingly innocuous request for information on a particular patient.

Heightened Awareness

The Government is not likely to change course in the foreseeable future. Every expectation is that things will get far worse before they get better. Every physician must, therefore ask, "what must I do to reduce the chances of being targeted by the Government?" Failure to take aggressive steps now can lead to serious problems later. As absurd as it may seem, many physicians may now be facing criminal prosecution for conduct that may would consider innocent, naïve, or simply well-intentioned. If one accepts the findings of the JAMA article referred to above, as much as one-third of the physician population, is at risk for intentional acts of caring. Many more, no doubt, are at risk for unknowing actions by staff or outside agencies.

In conclusion, no physician should forget, for even a moment that, no matter what the motivation may have been, there are no good excuses for ignorance, recklessness, or intentional acts of misrepresentation to Medicare.

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[8] A qui tam is a suit brought by an individual on behalf of the Government.

Ten Ways to Avoid Investigation

10. Institute a compliance program. However, understand that a compliance program is not a “get out of jail free card.” It may mitigate your exposure, but it will not eliminate it. An ill-conceived program can even create a standard of vigilance higher than that otherwise required by Medicare.

9. Aggressively resolve patient complaints concerning billing issues. Quick resolution of a patient’s problem will likely prevent a patient from reporting that irregularity to the Government. Remember, the Government is offering patients a $1,000 bounty for information leading to your conviction.

8. Review all of your vendor relationships. If you are billing based upon information provided to you by a vendor, beware. There is no protection under the law for physicians who rely upon incorrect instructions from a vendor on how to bill Medicare.

7. Train your office staff to bill and code correctly. This does not mean sending them to courses on “maximizing Medicare billing.” Training must include providing them with information on proper billing and coding, the risks of billing incorrectly, and what constitutes fraud.

6. Control and limit access to your billing operations and data base. There is no reason for every employee (including reception and non- billing staff) to have access to the billing systems. Billing should be a segregated function conducted only by those involved in the process. Information concerning billing should be provided on a strict “need to know” basis.

5. Monitor the actions and attitudes of your employees. “Whistleblower” claims brought by disgruntled employees are increasingly exponentially, encouraged by potential windfalls of up to 25% of any monies recovered.

4. Review everything you receive from Medicare. Review every Medicare bulletin and audit notice. Investigate claims that are routinely rejected. If a claim is rejected regularly, chances are there is an inherent problem with the claim. If the problem lies with the payor, discuss and attempt to resolve the problem directly with the payor or fiscal intermediary.

3. Hire consultants who will have access to your practice only through legal counsel. Consultants hired directly by a physician, who uncover improper practices, may be compelled to give testimony against you. Generally there is no privilege which protects them from testifying against you – or even acting as a whistleblower. However, if the consultant is hired by counsel, there is a good chance that any troublesome facts uncovered by the consultant will be cloaked within the attorney-client privilege and remain confidential, and non-discoverable.

2. Audit your own practice – today. You must know if you are at risk, and immediately take corrective measures to limit your potential liability and exposure. If you uncover any irregularities, discuss them with counsel and hire appropriate consultants only through counsel (see number 3 above).

1. Become immediately involved in the billing operations of your practice. “My office/billing manager handles all of that” and “I’m not involved in any of those issues, I am just practicing medicine” do not provide any form of protection. Remember “deliberate ignorance” is no defense. You must be involved in your billings. AS a physician it is you, not the billing clerk, that the Government is targeting.