INCREASING GOVERNMENT SCRUTINY OF MICHIGAN PROVIDERS: HOW TO AVOID BECOMING A TARGET

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On February 17, 2011, 111 defendants were charged in 9 different cities with defrauding Medicare for more than $225 million, 21 of which are from the Detroit area--including 3 doctors, 3 physical therapists and 1 occupational therapist. This marked the largest coordinated Medicare fraud action ever taken. However, Michigan is no stranger to such actions in recent years. The Healthcare Fraud Prevention & Enforcement Action Team (a/k/a "HEAT") has been active in the Detroit area since March 2009. HEAT is an intra-agency effort between the Department of Justice ("DOJ") and the Department of Health and Human Services ("HHS"). HEAT was formed to build upon and strengthen existing programs to combat Medicare and Medicaid fraud, and invest resources and technology to prevent fraud, waste and abuse. Agents from the Office of Inspector General from the Department of Health and Human Services (OIG), the DOJ, the Federal Bureau of Investigations (FBI), the Drug Enforcement Agency (DEA), and other federal and local law enforcement agencies have shared information and resources to investigate and prosecute fraudulent health care matters in both the criminal, civil and administrative realms. Medicare Fraud Strike Forces have had considerable success in detecting and examining potentially fraudulent activity and recovering money from those found guilty.

While the initial focus was on suppliers of Durable Medical Equipment, subsequent focus has been on providers of infusion therapy, physical and occupational therapy, and home health services. Allegations have included health care fraud, conspiracy to commit health care fraud, and money laundering. In addition to incarceration, prosecutors are also seeking forfeiture of criminal proceeds and restitution to the Medicare program. All providers who significantly rely upon Medicare and Medicaid funding should review their practices for compliance with Medicare and Medicaid regulations and policies to avoid becoming a target.

One of the reasons for increased enforcement actions in Michigan is the availability of additional "tools" to the federal agents to pursue suspected healthcare fraud. In May 2009, the Federal False Claim Act ("FCA") was amended by the Fraud Enforcement and Recovery Act ("FERA") which greatly enhanced the federal government's healthcare fraud enforcement powers. FERA expanded liability under the FCA to entities that indirectly receive government funds such as subcontractors and sub-grantees. FERA also eliminated the previous requirement that a party take an affirmative step (e.g., a false representation) to defraud the government. Under FERA, a person or entity can be held liable for simply retaining a federal overpayment even if the overpayment was not caused by their own fraudulent conduct (called a "reverse false payment"). FERA allows for civil investigative demands ("CIDs") to be delegated by the US Attorney General to other DOJ attorneys investigating alleged violations of the FCA. Previously, CIDs were rarely issued since they had to be personally approved by the US Attorney General. CIDs can compel oral testimony, document production and interrogatory

answers. FERA also expands the protection of whistleblowers to include contractors and agents (not just employees) and allows even the compliance officer or biller to be a whistleblower.

In addition to FERA, there have been changes to manner in which Centers for Medicare & Medicaid Services ("CMS") conducts its provider audits. Not only are recovery audit contractors ("RACs") scrutinizing Medicare payments for improper payments and being paid on a percentage contingent fee based upon the total amount of identified improper payments, CMS also employs Medicaid Integrity Contractors ("MICs") to scrutinize Medicaid payments. Although not paid on a contingency like the RACs, the MICs are similarly charged with conducting provider audits to identify fraud, waste and abuse. CMS also employs Zone Program Integrity Contractors ("ZPICs") to perform a wide range of medical review, data analysis and Medicare evidence-based policy auditing activities. While ZPIC audits are similar in many ways to other CMS audits currently being performed nationwide, they do differ in one very important aspect – potential Medicare fraud implications. Of all the current CMS audit initiatives – RAC audits, MIC audits, etc. – it is vital that providers facing ZPIC audits immediately and effectively address targeted audit issues as ZPICs focus on the areas deemed to be at the greatest risk for fraud by providers and report all cases to the OIG.

Another reason for increased enforcement actions in Michigan is the availability of additional "tools" to State agents to pursue suspected healthcare fraud. Effective January 6, 2009, our legislature amended the Michigan Medicaid False Claims Act increasing the civil penalties associated with submitting false claims to Medicaid, expanding the definition of "knowingly" to include acting with deliberate ignorance or reckless disregard (i.e., specific intent to defraud is no longer required) and allowing for "reverse false claims" similar to the federal FERA provisions, whereby it is deemed a violation if a provider retains an overpayment. The State of Michigan also now qualifies for an extra 10% of the recovery from the federal government for Medicaid false claims thereby providing increased incentives for the State of Michigan to investigate and prosecute Medicaid false claim cases.

In light of these increased "tools" of enforcement, what can a healthcare provider in Michigan do to avoid becoming a target? The following is a list of suggested proactive measures to be taken:

- Develop, implement and maintain a compliance program that includes education and continuing education of billing staff with a focus on proper documentation in accordance with third party payor guidelines;

- Identify risk areas through self-audits and review of the applicable third party payor publications and the annual OIG Work Plan; and

- Obtain and analyze your practice profiles from third party payors to understand how your practice compares to your peers to determine any aberrant areas of your practice that may need to be addressed.

Being proactive and spending the resources upfront will be far more cost effective in the long run.