New York Defers Hospital Clinic Audit After Complaints; Dialogue With States Is Key

The New York state Office of Medicaid Inspector General (OMIG) late last month suspended an audit of hospital-based clinics while it considers objections raised by hospitals. Medicaid Inspector General Jim Sheehan tells MCN the audit will resume, but he’s assessing the “direction and scope” of the review after meetings with the Healthcare Assn. of New York State and Greater New York Hospital Assn. The unfolding story underscores the importance of monitoring the premise and methodology of state and federal audits and communicating freely with program-integrity officials, experts say.

“[The hospital associations] raised serious concerns we are now evaluating,” Sheehan says. “OMIG’s goal is to do the audits we believe are appropriate, but to do them in a way that minimizes the burden on providers.”

The audit focuses on separate charges for services that should be bundled into clinic fees. In New York state, Medicaid pays clinics an all-inclusive fee for primary care services. It covers everything related to that visit, including diagnostic tests, with reimbursement capped at $67.50 per visit, says Albany, N.Y., attorney Mark Thomas, general counsel for the Healthcare Assn. of New York State. As the regulation states, “a threshold visit shall occur each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit. Only one threshold visit per patient per day shall be allowable for reimbursement purposes.”

continued on p. 9

Self-Disclosure to Feds of Potential Fraud Saves Hospital Money and Costly Litigation

After voluntarily disclosing that it had potentially received improper Medicaid and Medicare payments, Condell Health Network entered into a settlement agreement Dec. 1 to pay, without litigation, $36 million to the federal government and the state of Illinois. This settlement highlights the importance of self-auditing and voluntary disclosure, as Condell’s potential liability would be much greater if the government brought a lawsuit against it.

Self-disclosure can also help hospitals and other providers in the future when dealing with the state and federal governments on health care fraud issues, says one health care attorney.

According to U.S. Attorney Patrick Fitzgerald in Chicago, Condell, the parent corporation of Condell Medical Center hospital in Libertyville, Ill., made the voluntary disclosure while it was in the process of being acquired by Advocate Health Care. In a prepared statement, Condell said it was conducting internal audits when it discovered that contracts entered between Condell and medical staff members from 2002 through 2006 may not have been in full compliance with Medicaid or Medicare regulations.

The Condell case centers on potential violations of the Stark self-referral and anti-kickback laws. The settlement agreement states that Condell gave loans to physicians and improperly allowed them to “work off” the debts at hourly rates that were

EDITORIAL ADVISORY BOARD: JOHN FALCETANO, University Health Systems of Eastern Carolina, Greenville, N.C.; BRIAN FLOOD, J.D., KPMG LLP, Austin; FRANK SHEEDER, CCEP, Jones Day, Dallas; JAMES G. SHEEHAN, Medicaid Inspector General for the State of New York; DEBBIE TROKLUS, University of Louisville, Louisville, KY; DIANE UNG, Foley & Lardner LLP, Los Angeles; SHALINI WALIA, MPH, Strategic Management Systems, LLC, Alexandria, VA
greater than fair-market value. It also states that Condell
extended loans to doctors without assessing whether
there was a particular community need for these physi-
cians, provided loans to doctors already in the hospital’s
service area and entered into multiple loan agreements
with the same physician or medical group. Moreover, the
settlement stated that Condell received reimbursements
for paying doctors to perform services at the hospital
without required written agreements.

According to Condell, as soon as these possible vio-
lations were discovered, “the hospital took action to vol-
tarily disclose [them] to the United States Attorney for
the Northern District of Illinois.” Although the hospital
did not admit liability in the settlement agreement, it did
state that “we regret that in the past Condell may have
been engaged in any practices that were not compliant
with the law.”

Had Condell not voluntarily disclosed these poten-
tially fraudulent actions, the government could have
brought a lawsuit against it under the federal False
Claims Act (FCA). Liability under the FCA includes

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in communication between those with the knowledge of the change and those who have to implement the change. There must be follow-through from knowledge to the chargemaster, he says. This is a billing issue, but it’s “a critical billing issue.”

Another mistake, says Oliverio, occurs when a hospital spends thousands of dollars on establishing a compliance plan with, for example, hotlines and training, and then fails to update it over time and keep careful track of how it has executed compliance under the plan.

“There is nothing more powerful to show prosecutors” than evidence of what you’ve done in the past to comply, he says. For example, if a hospital can show that it has fired a charge nurse or a top doctor who was conducting potentially fraudulent activities, it will go a long way in showing that you are generally a compliant organization.

Contact Oliverio at doliveri@hodgsonruss.com and Condell Health Network through Christine Vicik at cvicik@condell.org.

**Hospitals Are Urged to Include Credit Balance as Compliance Risk**

An area identified in the HHS Office of Inspector General’s 2009 Work Plan as one that OIG will focus on in the upcoming year is Medicaid/Medicare credit balances, especially the failure to refund overpayments. And hospitals would be wise to brush up on their states’ laws regarding credit balances and review their patient accounts and compliance plans, says one health care attorney.

Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed. For an example, if a hospital receives payments for the same service from the Medicaid program or another third-party payer, the difference would be considered a credit balance and should be returned to the Medicaid program, which is the payer of last resort.

Federal regulations at 42 CFR 433 subpart F, “Refunding the Federal Share of Overpayments to Providers,”

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**North Carolina Medicaid Credit Balance Report**

<table>
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<th>Recipient’s Name</th>
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Circle One: Refund Adjustment Return Form to: Third Party Recovery
DMA 2508 Mail Service Center Raleigh, NC 27699-2508

SOURCE: North Carolina Department of Health and Human Services, Division of Medical Assistance, November 2007
require states to adjust any outstanding credit balances within 60 days after notification by a provider that a credit balance exists. Some state agencies have specific regulations in place requiring providers to refund Medicaid credit balances within a specific time frame, and some do not.

According to the 2009 Work Plan, OIG will review hospitals and other providers to determine whether there are Medicaid and/or Medicare overpayments in patients’ accounts with credit balances. It is not the first time that has appeared in the annual Work Plan, and OIG has been consistent about auditing providers on this issue.

Just last month, OIG released an audit report for Lakeview Hospital in Minnesota (A-05-08-00026), finding that the hospital had credit balances that included 23 overpayments totaling $5,000 that had not been returned to the Medicaid program.

OIG found that the overpayments occurred, and Lakeview concurred, because the hospital’s credit-balance review procedures lacked detail and its employees lacked training. Minnesota’s Medicaid program does not have any regulations in place requiring providers to refund Medicaid credit balances within a specific time frame. The statute states that providers must refund overpayment amounts to the state agency after they are identified.

Also, OIG conducted an audit of Baystate Mary Lane Hospital in Massachusetts in May 2007 (A-01-06-00010), finding 122 credit balances more than 60 days old that represented overpayments the hospital should have returned to the state Medicaid program. OIG found that the overpayments occurred because the hospital did not...
follow its internal procedures for processing and returning Medicaid overpayments. As in the federal program, the Massachusetts Medicaid program requires providers to return overpayments classified as credit balances within 60 days of receipt.

In conducting credit-balance audits, OIG identifies and reconciles hospitals’ Medicaid credit balances to its accounting records; reconciles the credit-balance list to the accounts receivable records and reconciles the accounts receivable records to the trial balance; and reviews patient payment data, Medicaid claim forms and remittance advices, patient accounts receivable detail and additional supporting documentation for each credit-balance account.

Credit Balances Are Specific Risk Area

One health care attorney, who is now involved in a lawsuit involving credit balances and asked not to be identified, tells MCN that hospitals should include credit balances in their compliance programs as an area of special concern. The specific risk with credit balances, he says, is the failure to refund, which can be seen by the feds and state governments as fraud and abuse.

Moreover, he recommends that providers become familiar with their particular state’s laws, since Medicaid is a state-run program. It is important to know if your state has specific time requirements or if it will follow the federal requirements, he adds.

For example, New York requires that any overpayments be repaid to the program within 30 days after third-party liability has been ascertained. As noted above, Minnesota does not have a specific time frame within which to return credit-balance overpayments.

Some states also require providers to submit on a regular basis reports detailing Medicaid credit balances (see table, p. 4). For example, in Virginia providers must submit a completed Medicaid Credit Balance Report each quarter, including a check and void/adjustment form to foster quick review and refunding of identified credit balances. Failure to submit the report can result in the reduction of a hospital’s Medicaid per-diem payment, according to the state regulation.

Providers in North Carolina must submit a quarterly credit-balance report (see table, p. 3), indicating balances due to Medicaid. Providers must report any outstanding credits owed to Medicaid that have not been reported previously on a credit-balance report, but hospitals must submit a report every calendar quarter even if there are no credit balances.


Whistle-blower Case Highlights Pitfalls in State UPL Programs

A whistle-blower case dismissed on summary judgment in August has gained recent attention because of a ruling on a motion related to charging the whistle-blower for court costs. In that October ruling, the judge said that he originally dismissed the case brought under the federal False Claims Act (FCA) because there was not enough evidence to prove the defendant knowingly violated Medicaid statutes. Because there was insufficient evidence, he said, the court simply declined to answer the question of whether the defendants were properly participating in a Medicaid program.

This statement is seen as good news for hospitals and other health care systems participating in state Medicaid programs. After all, says Dean Gresham, attorney for the plaintiff, it shows that “you can [allegedly] violate the law and not violate the” FCA. But other attorneys caution hospitals with similar arrangements to pay close attention to how they acquire federal Medicaid matching funds.

The whistle-blower, Linnea Rose, alleged a scheme by East Texas Medical Center (ETMC) Regional Healthcare System and ETMC Athens (ETMCA) to defraud the federal government of Medicaid matching funds for the Medicaid Upper Payment Limit (UPL) program. She filed a whistle-blower lawsuit against ETMC and ETMCA in 2005. The government declined to intervene, and the case was unsealed in February 2007.

In August 2008, Judge T. John Ward of the Eastern District Court of Texas granted the defendant’s motion for summary judgment, dismissing the case.

Gresham says that the week before the judge issued the summary judgment, Ward separated the defendants into two cases. Rose then voluntarily dismissed the case against ETMC, leaving ETMCA as the sole defendant. “I can’t comment on whether we re-filed [the case against ETMC], but if we did, it would be under seal,” Gresham tells MCN. He says the plaintiff will not appeal the summary judgment dismissing the ETMCA case.

“I would not even want to describe how foolishly I would be” to re-file, says Dean Davis, attorney for ETMCA and the ETMC system.

Through the UPL program, the federal government matches eligible state funds for certain hospitals participating in state Medicaid programs. Public hospitals are reimbursed at a higher percentage than are private nonprofit hospitals. Intergovernmental transfers (IGTs) are eligible funds transferred from one government entity to another.

ETMC operates hospitals in east Texas, including ETMCA. ETMCA is owned by Henderson County and leased to the Henderson County Hospital Authority (HCHA), and then subleased to ETMC.
The lawsuit alleges that HCHA opened a bank account using money provided by ETMC and then transferred this money to the state UPL program in order to receive matching funds. Gresham explains that “the seed money for what is used to participate needs to be local, public funds — not necessarily tax dollars” to fund the program. If hospitals do this, “they’re fine. But if they take private dollars and use them to fund it, then the only person funding the program is the federal government.” The federal medical assistance percentage (FMAP) rate requires the federal government to pay 60 cents and the state of Texas 40 cents for every dollar. “Local governments can fund Texas’ share of FMAP,” Gresham says. “Henderson County could have put up public funds. But ETMC used their money and put it into the Henderson County account. It was a brilliant scam.”

“The funds were public because they were sent by a hospital authority,” contends Davis.

**Attorney: Order Raises Issues Never Presented**

In late October, Ward ruled on the order to charge the relator (i.e., whistle-blower) for the court costs, saying that each side in the lawsuit must pay its own court costs. In that order, he noted that “the court declined to answer the question as to whether ETMCA was properly participating in the Medicaid UPL program.” Rather, “there were conflicting interpretations of the law, and the court found that neither parties’ (sic) interpretation was unreasonable.”

“I have no idea” why the judge included all of the information in the October motion, Davis tells MCN. “It was an order that should have been a one-liner. It was completely inconsistent with a motion. Issues raised never were ever presented to the court.”

Gresham emphasizes that in the summary judgment, the judge “did not make the finding that the hospital was appropriately participating in the Medicaid UPL program.”

There was apparently enough of a concern about the situation that in April 2008, the Texas Health and Human Services Commission (HHSC) suspended ETMCA’s participation in the UPL program. In letters to both the HCHA and ETMCA, the HHSC cites allegations of the Rose lawsuit. Gresham emphasizes that in the summary judgment, the judge “did not make the finding that the hospital was appropriately participating in the Medicaid UPL program.”

According to Davis, “there are a number of health systems and hospitals watching this case. I’ve had numerous calls” from lawyers representing hospitals and from hospitals and health systems as well. “The entire UPL program is so critical to hospitals that do inordinate amounts of Medicaid charity. Any kind of suggestion that the process...

Gresham says that there were some aspects of the case that may have made a difference for Rose. He says he had “key witnesses within the highest ranks at ETMC” that he had subpoenaed. “We tried to depose them, but ETMC refused to make people available,” he maintains. He adds that he had asked the court to compel them to testify, and that about a week away from the trial, the judge denied the request without comment. “I think the court didn’t understand that these were the same people who would prove” that ETMC “had the knowledge the court said the evidence needed to rise to,” says Gresham.

Davis, however, refutes this. “They ran out of time” to depose these people, he says. “There are ways to force people to testify, and they never” took any of these options, he adds. “We deposed everyone we thought was important for the lawsuit.”

Gresham also says that given the chance, he would have included the Texas Organization of Rural & Community Hospitals (TORCH) in the lawsuit as well. He says that TORCH has a vested interest in bringing its member hospitals — which ETMC hospitals are — into the program because it received 1 cent for every $1 these hospitals brought into the Texas UPL program. In a deposition, Susan Reed, vice president of TORCH, confirmed that from 2002 to 2007 TORCH received about $166,596 for ETMCA’s participation and about $413,761 for ETMC’s.

**Suit Alleged ‘Conflict of Interest’**

The lawsuit also alleged that the current general counsel for TORCH attended an HCHA board meeting and advised board members on how to fund the IGTs, which Gresham calls a “conflict of interest.” He says that ETMC never sought further feedback on the advice, which it should have. In the August 2008 summary judgment, Ward said that “even though ETMCA knew that TORCH had a financial interest in establishing ETMCA’s participation, the evidence does not suggest that ETMCA’s reliance on that advice was reckless.”

Davis adds that when his firm later looked at the advice from the general counsel, the advice “was exactly what we were able to confirm was appropriate.”

Gresham says that some TORCH board members were also board members at ETMC, and some ETMC board members were on the HCHA board — an “incestuous relationship.” Davis says he will “not dignify that comment with a response.”

According to Davis, “there are a number of health systems and hospitals watching this case. I’ve had numerous calls” from lawyers representing hospitals and from hospitals and health systems as well. “The entire UPL program is so critical to hospitals that do inordinate amounts of Medicaid charity. Any kind of suggestion that the process...
is called into question” will be of concern to these hospitals, he says.

Mark Armstrong, a senior attorney in Houston with Squire, Sanders & Dempsey, LLP, agrees that “those hospitals that are participating in UPL programs that have a similar structure to ETMC...would have a close eye on this case....If there was a medical center with a similar structure with respect to UPLs, they should probably understand the uncertainty in that type of arrangement.”

According to Gresham, there are at least two other hospitals in Texas that have the same approach as ETMC. “One of ETMC’s defenses was, ‘We’re not the only ones doing it,’” he says. ETMC “came forward with information on other hospitals funding the same way.”

Davis says that hospitals and health systems need to “be very certain there is good communication between the agencies that handle these programs for various states.” There can be various classes of qualifying hospitals (such as state government-owned or -operated and privately owned and operated), and “all have some unique differences that can be hooks in the process of trying to do this appropriately,” he says. “The rules are not easy to follow. Consequently, communication with these departments is very critical.”

And if hospitals aren’t sure whether they are compliant, they need to do whatever it takes to find out definitely. “You can’t stick your head in the sand and say everything is OK,” says Gresham. “You need to do your own due diligence, your own investigation and make sure that you are compliant.”

Contact Gresham at (214) 219-8828, Davis at (512) 343-6248 and Armstrong at marmstrong@ssd.com.

Alabama Sues CMS, Claiming Agency Issued Rule as a Letter

The state of Alabama has sued CMS, challenging the agency’s policy on how states must seek to recover Medicaid overpayments, damages, fines, penalties and other legal judgments or settlements.

The suit, Alabama v. CMS, M.D. Ala., No. 208-cv-00881-TFM (11/3/08), was brought in response to an Oct. 28 memo issued by the agency to state health officials clarifying that states must recover both the state and the federal share of Medicaid overpayments from litigation brought by states seeking damages, fines and penalties for fraud and abuse related to a state’s Medicaid program (MCN 11/08, p. 7).

Under Section 1903(d)(2)(A) of the Social Security Act, amounts recovered by a state through a state false claims act (FCA) action must be refunded at the Federal Medicaid Assistance Percentage (FMAP) rate. And states must return not only the federal amount originally paid attributable to fraud or abuse, but also an FMAP-rate proportionate share of any other recovery, says the letter.

States may recover solely their share only if the appropriate federal and state authorities agree to sever the federal and state portion of the overpayment and pursue them as separate actions. However, CMS stresses in the letter that if there is no formal agreement to sever, a state may not claim in a state FCA case that it is recovering only damages incurred by the state, and not the federal government’s portion.

The Alabama lawsuit, filed Nov. 3 by the state Attorney General Troy King (R) in the U.S. District Court for the Middle District of Alabama, seeks to permanently stop CMS from implementing “an illegal administrative regulation issued by federal authorities.” The complaint alleges that CMS exceeded its statutory authority by requiring states to return the federal portion of such recoveries at their applicable FMAP rate for medical services in recognition of the overpayment that resulted from a payment for Medicaid services.

The complaint also asserts that the letter expressly states that the requirements are not limited to actions brought by states against providers. But instead, the complaint says, the letter indicates that “states are also required to return the FMAP percentage on state recoveries based upon actions brought against third parties, such as actions against pharmaceutical companies, alleging inappropriate Medicaid expenditures.”

Attorney General Says CMS Is Shameless

According to a prepared statement from King, CMS is “shamelessly [seeking] to take the funds” from litigation brought by Alabama against 79 pharmaceutical companies. These funds “would have made Alabama whole from the very neediest and most vulnerable of all our citizens – our poor, our disabled, our children, and our elderly...[and CMS has] laid claim, through illegitimate and heavy-handed bureaucratic processes, to funds they did not seek to recover in the first place,” he asserted.

“Adding insult to injury,” says the complaint, the letter requires states to make these payments to the federal government regardless of whether the state has actually received the amounts in question. King says that the letter “took the incredible and ridiculous position that [the] agency demanded payment of the federal share of any amounts won by the state of Alabama in its average wholesale price litigation within 60 days of the entry of a finding of liability — trying to now confiscate monies that are being contested on appeal and of which Alabama has yet to receive even one dime itself.”

The complaint also alleges that the requirements imposed by the letter are invalid because CMS did not go
through the process of issuing a notice and asking for comments. It further states that the letter is unconstitutional because it requires states to return to the feds the federal share before deducting legal expenses, administrative costs and rewards to relators.

Moreover, the complaint argues that the requirements included in the letter are an unconstitutional tax on states and are arbitrary and capricious, and therefore invalid.

According to the complaint, the requirements included in the letter will deter states from pursuing providers for fraud and abuse because the states will bear the financial risk on their own.

Alabama has asked the court to set aside CMS’s Oct. 28 letter and permanently enjoin CMS and others from implementing its requirements. “We also are calling on President Bush to put an immediate stop to this power grab by the federal government. In addition we are asking for the assistance of our two U.S. Senators, Richard Shelby and Jeff Sessions, and all of our Congressional delegation, as well as Governor Bob Riley, in our battle to protect Alabama taxpayers,” says King.

CMS spokesperson Mary Kahn tells MCN that the agency is putting together a response to submit by the Jan. 5 deadline.


◆ A McAllen, Texas cardiologist was indicted Dec. 1 for Medicaid and Medicare fraud, according to acting U.S. Attorney Tim Johnson in Houston. Fabian Aurignac M.D., was arrested at a hearing regarding the suspension of his medical license after being indicted on eight counts of health care fraud. The indictment accused Aurignac of defrauding the Medicaid and Medicare programs by falsely and fraudulently submitting claims in connection with the use of unlicensed, foreign doctors and medical personnel and for billing for medical services not rendered. More than a year ago, the Texas Medical Board suspended his medical license for similar claims, and nine months ago the feds seized more than $1 million from his personal bank accounts. If convicted, he faces up to 10 years in prison and a maximum fine of $250,000. Aurignac did not respond to calls for comment before MCN press time. Go to www.usdoj.gov/usao/txs/releases/December%202008/120108Aurignac.htm.

◆ The Idaho Department of Health and Welfare’s Medicaid eligibility system contains thousands of errors because of lack of coordination between the automated computer system used to determine Medicaid eligibility and the computer system used to process payments, according to a state audit released Nov. 21. The audit report said “the last completed reconciliation was for a 13-month period and contained 23,240 errors,” with approximately 1,500 errors corrected within five weeks. “Based on these numbers, we estimate 400 errors and only 300 corrections occur each week, resulting in approximately 100 new errors that will not be corrected,” it said. Visit www.legislature.idaho.gov/audit/auditsummaries.htm.

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◆ A North Carolina internist has agreed to pay $1.7 million to settle allegations that he billed Medicaid, Medicare and the Federal Employees Health Benefits Program for more services than he provided, according to a Nov. 21 press release from U.S. Attorney for the Western District of North Carolina Gretchen Shappert’s office. Federal and state agencies investigated Benedict Okwara M.D., owner of First Care Medical Clinic, after the
program integrity section of the North Carolina Division of Medical Assistance notified them of potential billing problems, the press release said. Investigators allegedly found that Okwara was “upcoding” — billing Medicaid and Medicare for more extensive services than he actually provided — from 1999 through 2006. As part of the settlement, he agreed to reimburse the government for the amount he wrongfully received from the state and federal programs and pay “substantial” penalties. According to the U.S. Department of Justice, the $1.7 million amount represents more than twice the wrongful billings Okwara submitted to the government. He also agreed to enter into an integrity agreement with the HHS Office of Inspector General that requires him to hire at his own expense a government-approved auditor to monitor his billing practices for five years to “ensure that neither he nor his clinics commit similar offenses against government health programs in the future.” An attorney for Okwara could not be located. Go to www.usdoj.gov/usao/ncw/press/okwara.html.

◆ The owner of the National Degree Program (NDP) in Little Rock, Ark., was sentenced Nov. 13 on charges that he defrauded the Arkansas Medicaid program by submitting false claims to the program, according to Jane Duke, U.S. attorney for the Eastern District of Arkansas. NDP was promoted as an organization that provided social, educational, and medical services to Medicaid-eligible individuals, said Duke. After obtaining a Medicaid Group Provider number, from February to May 2006, Tyrone Williams submitted bills for targeted case management (TCM), she added. However, Duke said an investigation revealed that some of the bills were submitted for services not covered by TCM, such as taking clients on errands, paying their utility bills and tutoring certain clients for exams. Moreover, Williams inflated the time spent with Medicaid beneficiaries and billed for time expended by noncertified aides, she asserted. Williams was sentenced to two years in prison and ordered to make restitution of $49,117. His wife, who admitted knowledge of the scheme, was sentenced to three years on probation. Visit www.usdoj.gov/usao/are/news_releases/2008/November/williamstyrone%20sent%20HHS%20111408.pdf.

◆ A Joplin, Mo., dentist was arrested and charged with 13 felony counts of Medicaid fraud Nov. 13, Attorney General Jay Nixon (D) said. Samuel Miller D.D.S., was charged with submitting false reimbursement claims to Medicaid from November 2005 to June 2006 for services not performed on pediatric patients. According to the probable-cause statement by the Missouri Medicaid Fraud Control Unit, Miller billed Medicaid for procedures such as X-rays, root canals, resin-based composite restorations and amalgam restorations that he did not perform. The probable-cause statement also alleged that he “upcoded” services for reimbursement by submitting claims for more complicated procedures than actually performed and unbundled claims by submitting claims to Medicaid for individual parts of multi-step procedures. If convicted, Miller faces up to four years in prison and a $5,000 fine on each count. An attorney for Miller could not be located. Go to http://ago.mo.gov/newsreleases/2008/Joplin_dentist_faces_13_felony_counts_of_Medicaid_fraudFiled_jointly_by_Dankelson_Nixon/.

N.Y. Suspends Hospital Clinic Audit

Trouble started brewing when OMIG in early September sent hospitals collection letters for purported overcharging for clinic services, Thomas says. A majority of New York’s 220 hospitals got the letters, which required repayments for services provided at the hospitals’ outpatient clinics on the grounds they billed separately for services that should have been included in the all-inclusive fee.

But in the eyes of the hospitals, OMIG has taken the all-inclusive concept too far, expecting hospital-based clinics to swallow the costs of too many diagnostic tests and specialty referrals, even when they occur outside the clinic long after the primary care visit, Thomas says. For example, he says, many of OMIG’s letters to hospitals seek repayment for a course of physical therapy ordered by clinic physicians; OMIG contends the physical therapy is part of the all-inclusive fee, says Thomas, who is with the law firm Wilson Elser LLP.

The hospital associations brought their concerns to OMIG in September and have met twice with Sheehan...
and Deputy Inspector General for Audit John Foley.
“They have been long and good candid meetings. We
give them credit for listening and saying they need to
think about this,” Thomas says. (The overpayment
demands are on hold temporarily).

Hospitals knew this audit was coming because
OMIG told them in its first-ever Work Plan (MCN 5/08, p. 1). New York’s OMIG is the first state Medicaid integrity-program agency to set forth its audit and investiga-
tive targets for the coming year (fiscal year 2008).

OMIG described its plan to use data matches in 2009 to detect suspect billing for clinics and ancillary services. According to the Work Plan, “OMIG staff
performs numerous post-payment data matches which identify systemic behaviors which result in recoveries
from multiple providers.

OMIG will continue to perform existing matches for open time periods and will continue to develop
and prepare new data matches. A key goal in this re-
gard is to actively work with review staff (e.g., audit, investigative) and solicit new ideas for data matches
based on field experience.

Specific matches planned for the coming year include “identification of overlapping issues relating
to clinics billing all-inclusive clinic rates with servic-
ing providers billing Medicaid for related procedures, ancillary testing and physician services that should be
billed back to the clinic.”

Audit Methodology Troubles Hospitals

The underlying audit methodology of this work-
plan item troubles hospitals. “It did not appear [the state] looked at the regulations and used them to de-
velop data mining criteria,” Thomas says. “It appears
they came up with data mining criteria that seemed sensible to the OMIG but not in conformance with the contours of the regulation in question.”

Thomas says the regulation governing hospital-
based clinics says simply that Medicaid covers all medically necessary services provided during the clinic visit and ordered by the physician (e.g., blood work).

There’s no clear regulatory guidance for what diagnostic or specialty care is included in the “thresh-
old” clinic visit or what marks the cutoff (after which a service would no longer be considered part of the primary care visit), he contends. “Our concern is
that what they are doing is asking clinics to pay back Medicaid for services provided after a clinic visit that
should not be considered to be part of, or paid for by, the all-inclusive clinic rate,” he says.

Suppose a patient is treated at a hospital-based clinic and the clinic physician orders a CT scan. The
patient has the scan at an unrelated radiology center. OMIG’s position is that the CT scan is not separately
billable, Thomas says, because it was ordered by the clinic. “The question is, how can the clinic payment possibly cover the CT scan?” he says. “But auditors
say because it was referred by the clinic from the visit,
the CT scan is part of the all-inclusive visit. The regu-
lation cited in the demand letters does not support
OMIG’s position,” Thomas asserts.

He says OMIG also appears to have set 30 days as the window for bundling services into the all-inclusive fee. So if a clinic physician refers a patient to an ortho-
pedic surgeon and the visit occurs 27 days later, OMIG
still considers that part of the initial clinic visit. Aside
from the unfairness of the time gap, Thomas says,
there’s no regulatory authority for this position. (For example from OMIG, see p. 11)

Sheehan emphasizes that auditors will return to
work on the audit. “We believe the audit is based on
an appropriate reading of the rule,” Sheehan says.
“We want to be sensitive to the audit burden that is
imposed on health care institutions, but” when a pa-
tient visit and vaccination are charged separately, for
example, it’s “clearly wrong.”

He reiterates that the clinic fee is intended to be
all inclusive, extending, for example, to diagnostic services that arise as a result of the visit. “The core concept here is that if you are a doctor and you order a
test based on present illness, it is included in the clinic
fee,” he says.

For example, if a diabetic patient comes into the
clinic with symptoms of nausea and dizziness, and
the physician prescribes a fasting glucose test but the
patient has already eaten so she returns the next day
for the test, that’s included in the clinic fee. However,
if that same patient breaks his leg in the interim, treat-
ment for the broken leg isn’t included in the original
clinic fee.

Services Must Be Related

How does the state decide if the services are rel-
related? “There’s a series of things,” Sheehan says. For
example, who was the physician? What was the diag-
nosis? Do the diagnostic services relate to the diagnos-
is? What is the time period between the clinic visit and the other services? “The farther out in time, the
harder it is to connect [diagnostic and specialty ser-
ses] to the primary care visit,” he says, even if it’s the
same physician and same diagnosis.

Sheehan says OMIG intends to continue to meet
with the hospital associations to get feedback on im-
proving OMIG’s audit process. For example, some-
times services that seem related are not, and should be
paid separately. “The question is, what other evidence would be possible to show it was not related?

The issue the associations raised is, how much information should the hospital be asked for and in what time period, and what obligations should we impose on hospitals?” he explains. “We are having a good-faith discussion based on both.”

Sheehan says he will use the information he gets from the hospital association to help identify weaknesses in the audit program and to structure audits “in a way that minimizes the burden.”

Former Texas Medicaid Inspector General Brian Flood says communication between program-integrity officials and the health care industry is essential to working out problems. When he was MIG, Flood says, he had to “back off audits” a couple of times. “You hope there is dialogue between the industry and the [Medicaid integrity] agency so when those things pop up, they can be vetted before things get ugly,” says Flood, who is now a national managing director with consulting firm KPMG. “We had to change audit protocols and, in one instance, return money when we realized what had gone wrong. No one’s perfect,” he says.

As Medicaid audits ramp up across the country (along with Medicare recovery audit contractors), providers should review the laws and, regulations of every area under audit, Flood says. “Also look at the interpretation of that rule or code at the time the service was delivered because there have been instances with local interpretations that have been colored by [a contractor or regional office’s] view of the rule or law,” he says. “When they communicated that view to the provider, who relied on it, that created an implied contract or, at the very least, conflicting authority that needs to be vetted in the audit.”

Contact Thomas at mark.thomas@wilsonelser.com and Flood at bgflood@kpmg.com.

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**Examples of Improper Medicaid Clinic Billing From OMIG**

In response to complaints from hospitals, the New York state Office of Medicaid Inspector General (OMIG) has temporarily shelved an audit of hospital-based clinic services. The audit will resume, but its scope and substance are being reconsidered, a development that is a lesson for hospitals in the importance of monitoring state and federal audit activity and keeping lines of communication open with program-integrity officials (see p., 1). Below are four examples from OMIG of the kind of billing examined in this audit, which targets separate charges for services (e.g., ancillaries) from the all-inclusive fee that Medicaid pays for primary care clinic visits.

**◆** A patient was seen at an outpatient clinic for a routine child health exam. The clinic billed Medicaid $106.16. The attending physician billed another $87 for the same patient on the same day as the clinic visit for several injections, a urinalysis, a visual field exam and a pure tone screening test under his own provider ID. The billing by the attending physician for the services was inappropriate because only one threshold visit is allowable for reimbursement, and it includes the other services provided.

**◆** A patient was seen for glaucoma at a clinic, billing Medicaid $118.00. The clinic’s attending physician also billed Medicaid $60 under his own provider ID for ophthalmological ultrasound. Ophthalmological ultrasound is used in the evaluation of glaucoma. Only one threshold visit is allowable for reimbursement, and it includes the ultrasound.

**◆** A patient had two outpatient clinic visits at a hospital on May 15, 2006, and Oct. 3, 2006, for IV infusion associated with kidney cancer. On the same days, an additional charge was billed by the hospital for dextrose water J7060. The attending physician of the clinic was the prescriber of the dextrose water. Dextrose water is frequently used in the course of IV infusion for chemotherapy. Only one threshold visit is allowable for reimbursement, and it includes the dextrose water, which is included in the IV chemotherapy.

**◆** A patient went to an outpatient clinic for a urinary tract infection, and the visit was billed at the clinic rate. The next day, the recipient had a mammography ordered by the attending physician at the clinic. The clinic billed an additional $89 for the mammography (76091), which is both the technical and professional component. A physician billed separately an additional $36 for a screening mammography (76092), which is the professional component only. This billing was improper because the clinic cannot bill for technical and professional components for an ordered service at the same time a physician billed for a professional component for the same service (double billing). Further review would be needed to determine whether the mammography was ordered during the clinic visit.
NEWS BRIEFS

◆ The HHS Office of Inspector General (OIG) told New Jersey officials that its law does not meet qualifications set out in the Deficit Reduction Act (DRA). Under the DRA, states can qualify for an extra 10% of recoveries from Medicaid lawsuits brought under the state laws if they are similar enough to the federal False Claims Act. OIG explained in New Jersey’s letter that its state law (1) does not allow a whistle-blower to file a suit if there is a pending investigation, (2) does not allow suits based on allegations that are the subject of other pending actions, and (3) takes payments for the whistle-blower’s attorney fees out of his or her part of the settlement. Visit www.oig.hhs.gov/fraud/false-claimsact.asp.

◆ The Michigan state Medicaid agency did not properly pay inpatient hospital claims, and it claimed federal reimbursement for beneficiaries transferring from one hospital to another on the same day, OIG said in a recent audit report (A-05-08-00045). According to the report, the state agency made overpayments totaling $215,000 to 28 hospitals for 36 of 57 inpatient hospital claims reviewed. OIG determined that the overpayments were made because hospitals incorrectly coded the claims as discharges and claimed the full DRG payment instead of the transfer-prorated DRG payment. OIG recommended that the state agency refund to the feds its share of the overpayments made to 28 hospitals and ensure the system edits designed to detect and monitor these inpatient hospital claims are working properly. The state agreed with OIG’s findings and recommendations. Go to www.oig.hhs.gov/oas/reports/region5/50800045.asp.

◆ CMS issued a final rule narrowing the definition and scope of covered Medicaid outpatient hospital services by aligning it closely to the Medicare definition. According to the agency, this was done to improve the functionality of the applicable upper payment limits, provide more transparency in determining available hospital coverage in any state and generally clarify the scope of services for which federal financial participation is available under the outpatient hospital services benefit category. The rule went into effect Dec. 8, but CMS has reserved action on the provision due to a congressional moratorium prohibiting the agency from finalizing a related rule regarding cost limits for governmentaly operated providers. That moratorium prohibited finalization of six Medicaid rules until April 2009. Visit www.CMS_FRDOC_0001-0176.pdf.

◆ New York state improperly received enhanced 90% federal reimbursement for 102 family-planning claims submitted by clinics and practitioners, according to an OIG audit report released Nov. 13 (A-02-07-01037). Based on sample results, OIG estimated that the state received $17.1 million in federal Medicaid reimbursement. Part of this was overpayment, OIG said, because providers incorrectly claimed some services as family planning, and the state’s Medicaid management information system (MMIS) edit routines did not adequately identify claims unrelated to family planning. OIG recommended that the state refund the $17.1 million to the federal government, re-emphasize to providers that only services directly related to family planning should be billed as family planning and ensure that MMIS edit routines use all appropriate claim information to identify ineligible claims. It also recommended that the state determine the amount of federal Medicaid funds improperly reimbursed for claims unrelated to family planning after the audit period and refund that amount to the feds. The state generally agreed with OIG’s recommendations. Go to www.oig.hhs.gov/oas/reports/region2/20701037.pdf.

◆ The supplemental payments that Colorado made for mental health services provided to foster-care children in child-placement agencies were not fully consistent with federal and state requirements, according to a recent OIG audit report (A-07-06-04067). Based on a review of $23 million in supplemental payments, OIG determined that $3.3 million was unallowable because the state did not obtain CMS approval of contracts covering the supplemental payments from Aug. 13, 2003, through Sept. 30, 2004. Moreover, OIG found that the state did not provide documentation that the remaining supplemental payments were removed from the capitation payments that the state made to mental health assessment and service agencies. OIG recommended that the state refund the $3.3 million to the feds and work with CMS to resolve the undocumented supplemental payments. The state disagreed with OIG’s findings and recommendations. And based on the state’s objections, OIG modified its report and removed the finding of unallowable costs related to the failure to comply with state contract provisions and set aside the potentially unallowable supplemental payments. Go to www.oig.hhs.gov/oas/reports/region7/70604067.pdf.
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