

# Commentary

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## **Medicare Fraud: Up Close and Personal**

If you treat Medicare beneficiaries, you are now – as never before – a potential target of federal and state authorities. Indeed, even if you have long possessed a clear conscience, have never intended to defraud the government or any Medicare beneficiary, and have never harmed a single patient, you may still find yourself investigated by a Medicare carrier, the Office of Inspector General in the U.S. Department of Health and Human Service (HHS), or even an United States Attorney's office.

This new era of increased federal intrusion into private medical practice is the legacy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy-Kassebaum law. Although HIPAA presents a major challenge to medical care (and, in particular, to solo and small group practices), it is a challenge which can be met. But it will require your time, your energy, and your willingness to increase the amount of effort you expend documenting patient care decisions.

HIPAA has vastly expanded the funding, authority, and dominance of federal health care prosecutors over federal and state health care fraud and abuse investigations, audits, and prosecutions. HIPAA has also expanded the Medicare regulatory regime to embrace private insurance, causing risks previously limited to Medicare billings to reach many private health insurance claims. Between 1996 and 2001, Congress will spend more than \$1 billion on fraud and abuse investigations, audits, and prosecutions. Just two years after HIPAA's passage, the number of Assistant U.S. Attorneys assigned to health care fraud and abuse investigations has increased from 10 to 100. During the same period, the HHS Office of Inspector General increased its Medicare fraud and abuse staff from 700 employees to 2,000.

In 1998, the HHS Office of Inspector General will greatly increase the number of investigations of physician diagnosis, coding, evaluation and management coding; of billing for physician's assistants, billing for psychiatric services; and of physician investments and business arrangements. President Clinton has demanded that HHS increase the number of Medicare audits in 1998 to double the number in 1997. The HHS fraud investigation program that has resulted in dozens of successful prosecutions for health care fraud and abuse (Operation Restore Trust) will expand from five states to all 50 states in the near future.

While few question the wisdom of ridding fraud from the health care marketplace, HIPAA does much more than that: it enables Medicare to investigate large numbers of health care providers (innocent and fraudulent alike) in sweeps designed to uncover potential Medicare fraud and abuse for further investigation. Medicare determines the existence of fraud and abuse largely from patient files. In doing so, HIPAA will, from time to time, erroneously result in instances of inadequate documentation being equated with fraud or abuse.

There are no safeguards in the law to minimize the risk that innocent health care providers will be wrongly accused. Indeed, HIPAA makes it possible for Medicare to scrutinize millions of claims across the nation, and to commence investigations against large numbers of providers based on billing irregularities that heretofore were deemed unremarkable or went unnoticed. Billing irregularities that can trigger investigations can be as simple as unintended errors in coding or as complex as alleged failures to deliver the kind of care Medicare deems appropriate for a Medicare beneficiary's diagnosed condition. A single billing irregularity can lead to investigation of a physician's entire Medicare billing history, resulting in the physician being forced to disclose a substantial number of patient files to Medicare investigators.

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When Medicare beneficiaries enter the Medicare program, they waive their right to privacy to permit Medicare at any time to review the contents of their patient files. A demand from Medicare for a beneficiary's file is one which neither the patient nor the physician may lawfully oppose. Attempts to "prepare" a patient file for investigators, even if merely to include undated documents not previously included in the file, can be the basis for severe actions, including criminal fraud charges. Attempts to obstruct federal investigators or to mislead them are also subject to severe penalties under HIPAA and to new criminal sanctions in the law.

Perhaps the most insidious aspect of the new law involves its creation of a new class of ambulance chasers: attorneys who will look to former disgruntled employees and dissatisfied patients of a health care provider, and will convert that angst into litigation against the provider. HIPAA includes provisions that encourage disgruntled employees and patients as well as watchdog groups to file complaints with the HHS Office of Inspector General or the Department of Justice alleging fraud or abuse in exchange for the promise of a portion of the money recouped from the health care provider. The law presently lacks any safeguards to minimize the risk of false complaints which – given the promise of "found money" – are all too likely. Each complaint triggers an investigation that may cause all Medicare billings (not just those identified by the complaining party) to be examined for irregularities.

Existing federal law provides another method for disgruntled former employees and patients, as well as ordinary members of the public, to become enriched through attacking a health care provider – the so-called "Qui Tam" lawsuit. Qui Tam lawsuits ("kwee tamm," from the Latin, "who sues on behalf of the king as well as for himself"), are expressly permitted under the Federal False Claims Act. The Qui Tam provision allows a private citizen to file suit in the name of the U.S. Government, charging fraud by any entity who has received government funds, and to share in any money recovered by the lawsuit. Such an undertaking for a private citizen is not as daunting as it might appear. The Internet today abounds with websites dedicated to providing assistance and "self-help" to would-be Qui Tam plaintiffs and their lawyers.

HIPAA and Medicare's expansion of the definitions of Medicare fraud have substantially increased the number of Qui Tam suits being filed. Federal law allows a private party to recoup as much as 15-35 percent of the judgment amount in return for instituting a Qui Tam lawsuit. A Qui Tam suit is filed under seal (the party accused cannot see the initial complaint). The Department of Justice then evaluates the claim and determines whether it wishes to prosecute the case. If the Department of Justice elects to proceed, the government will prosecute the case, but the original complaining party is still paid 15-35 percent of any proceeds ultimately obtained. In 1997, the average Qui Tam case filed under the Federal False Claims Act included a claim of \$1 million with \$200,000 going to the complaining party. In the famous SmithKline Beecham suit, the original complaining party will receive \$52 million. In 1997, four out of five of the largest Qui Tam lawsuits involved alleged health care fraud, a pattern destined to continue.

Former employees, patients, and opportunists are not the only ones cashing in on HIPAA; federal health care prosecutors are also enjoying the spoils. Moneys recouped from health care providers under HIPAA's provisions are placed in a trust fund and transferred back to the Department of Health and Human Services to finance more health care fraud and abuse investigations, audits, and prosecutions. HIPAA is thus a litigation machine with no off-switch – a self-perpetuating bureaucracy that increases its power and funding every time it causes a health care provider to reimburse Medicare in response to a charge of fraud or abuse, regardless of whether the charge is fair, just, or appropriate. The law is a cruel and costly trap for the unwary.

Another cruel aspect of the Medicare reimbursement machine is its stealth. A Medicare carrier can merrily pay claims erroneously for years, only later demanding that the health care provider reimburse the carrier based on a billing irregularity. The carriers are rarely punished for mistakes of this kind as long as they collect from the health care provider who has received the moneys. That is because, many years ago,

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Medicare placed the burden of proving the propriety of a claim payment not on the payer, but on the health care provider payee. Thus, while it is logical to believe a payment signals Medicare's determination that a claim is appropriate, logic has little place in this draconian system. Many providers are coming to the startling realization that the tens of thousands (if not hundreds of thousands) of dollars they received from Medicare over the past decade are subject to being repaid to Medicare on pain of prosecution, exorbitant interest penalties, and years of litigation.

In short, HIPAA – a law written by prosecutors for prosecutors – is a prosecutor's dream and a defense attorney's nightmare. In 1996, the Department of Justice investigated 2,488 alleged instances of civil health care fraud. In 1997, the HHS Office of Inspector General reported that \$1 billion was recouped from Medicare and Medicaid providers. Both of these numbers are bound to increase dramatically in the next few years. Moreover, for the first time in their professional careers, physicians (especially those in solo and small group practices) will be the recipients of Medicare information inquiries and the subject of Medicare investigations.

Unless HIPAA is changed to ensure that those innocent of an intent to defraud are freed from the costs of investigations and audits, and to include procedural safeguards to protect providers from the costs, defamatory effects, and professional fees lost due to wrongful investigations, audits, and prosecutions, this law may well drive single and small group practices out of business. The ultimate legacy of HIPAA may be that it functioned like a neutron bomb: it left large managed-care HMOs and PPOs (those entities that could afford the attorneys and accountants needed to document and justify every treatment decision) standing, while it vanquished solo and small group practices. Clearly, rumors of the death of President Clinton's health care plan have been premature, as a highly bureaucratized health delivery system may be a fait accompli as a result of the implementation of HIPAA.

Although HIPAA is draconian, there are definite steps that can be taken to reduce risks to a bare minimum. Indeed, the time has come for every health care provider to evaluate in painstaking detail patient intake procedures, recordkeeping, follow-up, and use of consent forms and advance beneficiary notices. A combined approach of careful documentation in a manner preferred by Medicare, and adherence to quality patient care will do much to diminish risk. Several independent organizations offer professional training for billing staff, and professional guidance for health care providers.

Now is the time to obtain that help. An investment in knowledge and an application of that knowledge can mean the difference between fighting a legal battle for years and avoiding a legal battle entirely. With Medicare as with life, prevention is the best cure. In the end, contemporaneous records that document clinical histories, treatment decisions, and treatment outcomes; obtaining informed consents and advance beneficiary notices associated with patient care; and the precision with which CPT codes are used will make all the difference in the world. Learning what to document, when to document, and how to do so appropriately and efficiently is critical.

In this brave new world of HIPAA, the bureaucrat's largest obstacle to successful prosecution lies in paper. There is no substitute for thorough, contemporaneous documentation to support your patient care and billing decisions. The adequacy of the Medicare paper trail has become all important.

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