



Health Care Fraud Alert

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In a “First in the Nation” Move, Florida More Than Doubles Its Data-Mining Capabilities to Detect Health Care Fraud

The economic downturn has forced government officials to seek innovative ways to combat the growing problem of health care fraud. Toward that end, Florida sought a waiver of the federal regulation that effectively prohibits more than one State government agency from “data-mining” the billing records of Medicaid providers.

Last week, the waiver was granted and as a result, Florida has more than doubled its electronic data-mining capabilities to pursue health care fraud in the Medicaid program. In addition to the 100 analysts at the Agency for Health Care Administration (“AHCA”) who already do this work, the 136 sworn law enforcement agents of the Attorney General’s Medicaid Fraud Control Unit (“MFCU”) will now police the electronic billing records of the State’s Medicaid providers.

With an annual Medicaid budget of \$18B, and fraud estimates ranging from 5-20%, State officials hope to see a significant uptick in fraud investigations and prosecutions by opening up

Medicaid billing records to greater scrutiny. Florida is the first State to be granted such a waiver, and others are expected to follow.

In their waiver request letter to the federal regulators, Attorney General Bill McCollum and AHCA Secretary Thomas Arnold pointed out that Florida’s large Medicare budget could also be affected. McCollum plans to first target medical billings for seniors in order to detect fraud in both the Medicaid and Medicare programs.

AHCA has been data-mining for years. On any given day, AHCA financial analysts and investigators are conducting a wide array of electronic tests on Medicaid billings looking for trends that suggest fraud, including overutilization, up-coding, unbundling, and double billing. They employ both internally designed software and fraud detection software developed by various vendors. They watch for rapid increases in billing and payment rates. They refer suspected fraud cases to their field agents for recoupment efforts or to the Attorney

General’s Medicaid Fraud Control Unit for criminal investigation. Now, the MFCU will not have to wait for referrals from AHCA, but can mine the data as they see fit based on their experience and training as law enforcement officers.

They will be looking for, among other things: (1) providers who bill for phantom patients; (2) billing for services and/or equipment that wasn’t provided, isn’t medically necessary, or is no longer needed; (3) overcharging; (4) double billing; and (5) misuse of Medicaid provider and recipient numbers.

When medical billing data-mining leads to an enforcement action, the provider can expect a number of events to happen: payments can be withheld pending the outcome of the investigation, patients can be interviewed, employees subpoenaed, and facilities checked. The law allows MFCU agents to enter a medical facility and inspect medical records, with minimal notice. When they enter the premises, MFCU agents can investigate not only Medicaid fraud, but any

suspected criminal activity that comes to their attention during the inspection.

Repayments for improperly documented billings can be calculated by AHCA without a complete audit, by using legislatively authorized statistical estimating formulas that the courts have sanctioned. Fines can be equal to treble the amount calculated as improperly billed, and if part of a criminal sentence for fraud, can be equal to five times the amount alleged as improperly billed. If convicted of fraud, a provider can lose eligibility as a provider, or worse, can be the subject of court ordered reorganization or dissolution. Prison time for serious offenders is also a distinct possibility.

Physicians, hospitals, nursing homes, pharmacies, home health care and durable medical

equipment providers must always be on guard for billing errors that could lead to an investigation beyond a mere audit. Clerical mistakes, sloppy record keeping, and inattention to detail can lead to serious allegations by the government if gone uncorrected.

On the other hand, data-mining is a tricky task to delve into without a thorough understanding of the data being mined and the milieu in which it was created in the first place. "Fraud indicators" can stem from a bias that infects the creation of the testing algorithms. Sample sizes that are too small or are overly inclusive could lead to erroneous conclusions. "Medical necessity" or lack thereof, is the toughest of all judgment calls. Unless a provider vigorously defends against a claim of falsifying medical billing records, the possibilities for enforcement errors may not be brought to light.

The Attorney General's MFCU investigators will start data-mining Medicaid billing records in January 2011. Medicaid and Medicare providers who have been procrastinating on billing training and verification protocols should pay heed. The State has more than doubled the number of data-miners in its enforcement brigade. ■

**Courtesy of Berger Singerman's White Collar Criminal Defense and Special Investigations Practice Group with offices in Fort Lauderdale, Miami, Boca Raton and Tallahassee.*

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Melanie Ann Hines
Sharon Kegerreis
Charles Lichtman
Etan Mark*
Stefanie C. Moon

(850) 521-6722
(305) 714-4393
(954) 712-5138
(305) 714-4360
(954) 712-5151

MHines@bergersingerman.com
SKegerreis@bergersingerman.com
CLichtman@bergersingerman.com
EMark@bergersingerman.com
SMoon@bergersingerman.com

*Also a Certified Fraud Examiner