Medicaid Inspector General — Fasten Your Seatbelts

By Marguerite A. Massett, Esq., Partner, Hancock & Estabrook, LLP

In early June, the state legislature confirmed James Sheehan as New York's Medicaid Inspector General. New York is now one of only two states (the other being Texas) with an independent Medicaid Inspector General who reports directly to the governor. Sheehan, a long-time federal prosecutor, comes to his new position with significant credentials in successful — and aggressive — health care fraud and abuse prosecutions at the national level. He assumes the reins of New York's relatively young Medicaid fraud fighting office just in time to take the state's new False Claims Act for a test drive. The new law not only arms the Office of the Medicaid Inspector General (OMIG) with additional authority, but also offers financial incentives for whistleblowers who identify and assist in prosecuting successful health-care-related fraud and abuse cases. Sheehan has publicly stated that his No. 1 priority is securing $1.5 billion in additional federal Medicaid funding for the state — funding that is conditioned on materially increasing New York's financial recoveries from Medicaid fraud enforcement activities. With a new Inspector General wielding an array of statutory enforcement tools, New York physicians and other health care providers may wish to consider the advice of Bette Davis' famous character Margo Channing: "Fasten your seatbelts. It's going to be a bumpy night."

Previous columns have discussed the 2006 changes to New York's Medicaid program related to mandatory health care compliance programs (see *M.D. News,* March 2007). In April of this year, a new False Claims Act took effect, mirroring a federal law in existence since the mid-1800s. While not exclusive to Medicaid, the new law has implications for health-care-related fraud and abuse enforcement because it creates significant penalties in cases of knowing submission of false or fraudulent Medicaid claims. The act, while stating that mere "negligence" in submitting claims is not actionable, provides that a violation can occur even if the provider submitting the claim did not intend to defraud Medicaid or lacked specific knowledge of the false or fraudulent nature of the claim. Clearly, submitting a claim that one knows to be false or fraudulent is a violation. The law is also violated, however, if the provider submits an inappropriate claim with "deliberate

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GETTING AN ACCURATE PICTURE

Before beginning an internal billing audit, determine what type of sample you'll use and the tools you'll rely on to determine whether claims are appropriate. For example, you may want to select a certain number of records from Medicare and Medicaid and another number randomly chosen for each physician. Then look at the selected records to see whether the codes used accurately reflect the service performed, whether the physician and practice identifier numbers are correct and whether the service was properly documented.

Payers have different definitions of medical necessity, so the auditor should consider whether the medical record supports the relevant payer's definition. The auditor also should look at whether the documentation on the patient's chart is appropriate for the billed service. Finally, the auditor should ensure all the services provided have been billed. If you order a routine blood test, for instance, and the nurse provides it, which one of you is responsible for telling the billing staff about it? Overlooking such details can cause a significant loss of revenue.

TAKING FULL ADVANTAGE

To get the most advantages from internal billing audits, conduct them annually. Also set up processes to routinely monitor billing practices going forward. Heightened staff awareness and monitoring can go a long way toward ensuring plans to correct billing errors are working and that new errors aren't creeping in. You'll be forced to write off enough claims, don't let yourself get hurt unknowingly.

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ignorance" or in "reckless disregard" of the accuracy of the information in the claim and/or its legal permissibility. The onus is on the provider to show that reasonable steps were taken to understand and comply with billing rules and to verify the accuracy of information submitted in Medicaid claims.

In addition to establishing this new violation for false or fraudulent claims, the act creates a powerful new enforcement mechanism. It offers "whistleblowers" — individuals who alert enforcement officials to cases of possible Medicaid fraud (technically referred to as "*qui tam* relators") — an opportunity to receive a portion of the state's financial recovery in any case arising from such individual's report. While New York law already prohibited retaliation against employees who, in good faith, report possible Medicaid fraud, the new law provides financial incentives for them to do so. In a slightly ironic turn, changes in federal law that took effect in January 1, 2007 (See *M.D. News,* March 2007), require New York hospitals and certain other health care providers to educate their employees on their ability to act as *qui tam* relators and the potential financial incentives.

Inspector General Sheehan made his support for the *qui tam* provisions clear in comments during the recent Northeast Conference of the Health Care Compliance Association. He indicated that he considers the whistleblower program to be a valuable, effective and efficient tool to combat Medicaid fraud and an important factor in permitting OMIG's resources to be focused on enforcement avenues that present the greatest potential for the highest return. In addressing the issue of increasing New York's Medicaid fraud recoveries, Sheehan acknowledged what Gov. Eliot Spitzer has identified as the primary goal for OMIG in the coming year — to assure that New York recovers sufficient Medicaid funds to qualify for the first installment on $1.5 billion in additional federal Medicaid funding that is available over the next five years. The additional federal funds are conditioned upon, among other things, New York reaching ever-increasing annual Medicaid fraud recoupment targets, starting with the federal fiscal year beginning October 1, 2007. New York must recoup $215 million from fraud and abuse enforcement initiatives in year one, increasing to $644 million in year five, in order to receive the full $1.5 billion. These aggressive recoupment targets will likely mean that OMIG and the other state enforcement agencies (including the Medicaid Fraud Control Unit within the Attorney General's office) will increase their efforts. Not surprisingly, Sheehan has indicated that this fall, providers should expect additional guidance from his office on how to self-disclose identified overpayments. Self-disclosure can, in certain circumstances, limit penalties to which the provider might otherwise be subject. Like the whistleblower program, Sheehan has referred to self-disclosure protocols as useful and a cost-effective tool in the fight against Medicaid fraud.

As a federal prosecutor, Inspector General Sheehan was nationally known for successfully uncovering and prosecuting health care fraud and abuse cases. Now, with specific dollar goals on the table and significant federal funding at stake, providers should expect — and prepare for — him to live up to his reputation.

Mrs. Massett, J.D., a partner with Hancock & Estabrook, LLP, has diverse legal experience in health care operations, insurance, reimbursement and public policy. She also advises clients on health-care-related compliance issues such as antitrust, fraud and abuse, and governmental enforcement actions. Previously, Mrs. Massett served as general counsel to a multi-hospital health care system and as in-house counsel to a national managed health care corporation. In addition, she has served as a public policy advocate in Washington, DC, specializing in health care delivery and financing issues. Mrs. Massett is admitted to practice in New York and Connecticut. ■

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