

# UPDATES FROM BARATZ & ASSOCIATES, P. A. FOR THE HEALTHCARE INDUSTRY

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## SUMMIT BRINGS TOGETHER HEALTHCARE MOVERS AND SHAKERS TO DISCUSS ADDITIONAL FOCUS ON HEALTHCARE FRAUD

On January 28, 2010 a pretty impressive list of presenters attended a National Summit on Healthcare Fraud at the Natcher Conference Center at the National Institutes of Health to discuss and brainstorm with government and private sector representatives of the healthcare industry. The list of speakers included U.S. Department of Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder along with other members of the Department of Health and Human Services, Department of Justice, FBI and other speakers such as U.S. Representative Ron Klein (FL-22) and James Roosevelt, Jr., CEO at Tufts Health Plan. This was the first national gathering on healthcare fraud between law enforcement and the private and public sectors and is part of the Obama Administration's coordinated effort to fight healthcare fraud.

As Secretary Sebelius stated, "The Obama Administration has zero tolerance for healthcare fraud and abuse" and announced at the summit "the President's FY2011 budget being unveiled next week will include historic support for anti-fraud efforts... requesting \$561 million, an 80% increase in discretionary funds to support programs like the strike forces (HEAT), which are realizing impressive results by prosecuting criminals and returning dollars back to the taxpayers." She also noted that these types of meetings provide a great opportunity to "swap best practices for screening providers and analyzing claims."

Attorney General Holder called the scope of the healthcare fraud and abuse problem "shocking" and compared the estimated \$60 billion in public and private healthcare spending felt to be lost each year to healthcare fraud to the blockbuster movie hit Avatar (the highest earning movie of all time) by noting that the possible losses are "33 times the amount of money that Avatar has made at the box office."

As is many times the case at these types of events, "shock treatment" is used to get attention but some of the "shock treatment" used is compelling. Holder noted that "last week

the Department of Justice settled False Claims Act allegations against a dental management company that was operating 70 clinics across the country. These "Small Smiles Centers" served young children in predominantly low-income areas. But instead of treating kids, this company was exploiting them to siphon millions of dollars from Medicaid. Many of these centers performed unnecessary and often painful dental procedures on unsuspecting, helpless children. In some cases, parents were told that healthy teeth needed to be removed. For putting profits above patient safety, this company will pay a \$24 million fine, plus interest. And we are continuing to investigate the individual dentists who participated in this scheme."

So where does this lead us? Elizabeth Carder-Thompson the President of the American Health Lawyers Association attended the Summit and had a number of observations. Some of these included:

- 1) There will be heightened cooperation and more aggressive, coordinated enforcement in the public and private sectors to combat fraud, abuse and waste. The main focus used to be Medicare fraud - now it is healthcare fraud across-the-board.
- 2) Increasingly, efforts will be directed at fraud and abuse preventions and pre-payment scrutiny, rather than just focusing on "pay and chase" enforcement.
- 3) There will be increased attention paid to data coordination. Currently, Medicare, Medicaid and private payers collect and maintain data in different ways, making utilization and other "patterns" comparisons difficult. This is going to change.

- 4) Governmental entities are directing their resources in a more data-driven targeted way in order to identify fraudulent patterns.
- 5) There will be greatly increased efforts to engage the general public Medicare beneficiaries, their families and others in whistleblowing.

Although the government agencies, as well as private insurance agencies, are not always correct, some of the "shock stories" intensify the desire for heightened scrutiny and action in areas that may appear to be questionable. In some cases their suspicions may be founded in facts and in some cases not. The only way to try to prevent getting caught in the investigative and enforcement crossfire is to know your business well, have compliance plans in place, follow those compliance plans, act on areas of concern quickly and effectively and most of all make sure that you have the personnel equipped to make sure you are doing things correctly.

Regardless of what you think of Summits such as these and some of the stories, predictions, and statements made, the intensity with which lawmakers, regulators and enforcement agencies will be looking at the healthcare industry in the foreseeable future is sure to increase.

## **MORE HOSPITAL SYSTEMS SETTLE FALSE CLAIMS ACT ALLEGATIONS**

It seems to be a recurring theme with monthly settlements showing up between the Department of Justice and providers. On December 22, 2009, an Oklahoma Hospital agreed to pay the United States \$13.2 million to settle allegations that it violated the False Claims Act. This stemmed from an April 2008 self-disclosure report submitted by St. John Health System to the Department of Health and Human Services Office of Inspector General (OIG) that acknowledged that physician agreements they had entered into may have run a foul of federal law. This is another situation where the cost of making mistakes (intentional or unintentional) can be dramatic.

In another case involving Genesis Health System of Michigan, a contracted auditor uncovered billing issues that alleged higher levels of service were billed than were actually rendered between 2001 and 2007 resulting in a whistleblower claim being filed. The settlement for \$669,413 to settle the false claims allegations resulted in a \$133,882 payment to the whistleblower.

An article published in Modern Healthcare dated February 3, 2010 discussed a tentative agreement between the U.S. Department of Justice and Christ Hospital in Cincinnati and its former parent, the Health Alliance of Greater Cincinnati, that would resolve allegations that the hospital assigned panel time on its cardiac diagnostic unit to the most lucrative physicians. The settlement terms have not been disclosed. An order to dismiss the case, as long as the settlement is finalized, was entered in U.S. District Court in Cincinnati. This is the second known instance of a competing cardiologist bringing a whistleblower suit against a hospital system alleging a preferential policy of assigning greater panel time to cardiologists whose procedures earned the most revenue for the hospital. According to a written statement from Christ Hospital "we cannot comment on any terms of the settlement because the parties are currently finalizing the written agreement; however, this settlement allows the hospital to avoid the risk of the multi-billion dollar award sought by the government."

Based on this, information provided in previous newsletters and the discussions at the recent summit discussed earlier, problems can come and will come from a multitude of directions. It could be more sophisticated data sharing systems, internal whistleblowers, external whistleblowers or just from your own compliance due diligence. Either way they can be costly. Be careful out there!!

Note: Elizabeth Carder-Thompson is a partner with the law firm of Reed Smith, Washington office. Her comments in full can be found on the Life Sciences Legal Update at Reed Smith ([rswebsite@reedsmith.com](mailto:rswebsite@reedsmith.com))

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