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Balanced Budget casualty, p. 3
[illegible] Wall Buildings, p. 8

New teeth for Florida's fraud busters

By ANGIE ANTONOPOULOS

Fraudulent providers scheming to cheat Florida's $7 billion Medicaid program could soon be caught a lot faster, thanks to new ammunition from the state legislature and beefed-up support from the federal government. While support for fraud cleanup is widespread, not everyone is convinced the new methods will deter those wrongfully feeding at the public trough.

"Fraudulent providers beware," warned Ruben J. King-Shaw, Jr., executive director for Florida's Agency for Health Care Administration. The combined artillery of the Medicaid Fraud Control Unit, a new multi-agency task force in South Florida, increased technology and recent legislation, "give the process more teeth while also balancing the rights of the providers," King-Shaw said. "We are not on a witch hunt, but we will be tough on fraud."

House Bill 2125, which awaits the Gov. Jeb Bush's signature, will enable the AHCA to stop payments on suspicious claims immediately if fraud is suspected. The measure will also give the agency greater access to providers' offices and records.

The tough action is not directed to honest providers, King-Shaw said. This is "for people determined to commit fraud. They lie awake at night thinking of ways to do this."

Stopping payments sooner

But some of the bill's vagueness worries providers. "What constitutes suspicious?" asked Terry Fields, vice president of operations for Fort Lauderdale-based Pediatric Associates, which billed more than $1.5 million in Medicaid claims last year. "The real key to this is how the intent of the bill will be implemented in the day-to-day process. That's where the rubber meets the road."

"We don't like to see bad apples," agreed Ken Kassin, M.D., CEO of Trinity Ob-Gyn, which has 18 offices stretching from Fort Pierce to Fort Lauderdale and a patient base that is 50 percent Medicaid. "It doesn't do good for the barrel."

The AHCA, which collected $18.4 million from fraudulent providers in 1998, will not only reverse what it calls its previous "pay and chase" method, but for the first time, can descend upon a physician's office after 24 hours if the doctor and agency cannot agree on a time to meet to resolve a billing claim.

"While we're making progress, there's a lot that needs to be done," said Mark H. Schlein, assistant attorney general and director of the Medicaid Fraud Control Unit. "It's very difficult to chase money already out the door. The sooner we can stop payment, the more likely we are to stop the abuse."

Kassin, the ob-gyn, said he has no problem with the search-on-short-

see MEDICAID page 7

NO FRAUD HERE: Ken Kassin, M.D., CEO of Trinity Ob-Gyn, has no problem with investigators scrutinizing his records even on short notice.

New multi-agency anti-fraud hub to open

Armed with $3 million in funding, federal, state and local law enforcement will combine forces in South Florida to nab providers and recipients cheating the system, announced U.S. Senator Bob Graham and Florida Attorney General Bob Butterworth last month. According to officials, the region is a haven for much of the nation's healthcare fraud and abuse.

The partnership, which was recommended by Graham and approved by the U.S. Department of Justice, will make South Florida a location as a prototype for a new, multi-agency investigative storage and support facility. The facility will most likely be open by fall, reports the AHCA.

Officials say the anti-fraud hub will help:

- Decrease duplication in investigations
- Designate a lead agency in fraud cases which have multi-jurisdictional interest
- Provide investigators and prosecutors access to volumes of medical documents and databases for their analysis

"This type of cooperation is exactly what we need," said Ruben J. King-Shaw, Jr., AHCA executive director. "While the agency already works closely with the federal office of Operation Restore Trust in Miami to identify, investigate and prosecute health care crooks, this new system should speed up the processes involved in these kinds of investigations."

The anti-fraud facility will be funded by the Health Care Fraud and Abuse Control account created by the Health Insurance Portability and Accountability Act of 1996. Furthermore, the U.S. Department of Health & Human Services contributed $2 million and the U.S. Department of Justice contributed $1 million for the South Florida hub. ◆

Feds eye Medicare players who 'game the system'

By BURT SCHORR

Medicare HMOs and other risk plans whose members disenroll and then receive costly services and procedures paid under Medicare fee-for-service can expect closer scrutiny by the Health Care Financing Administration (HCFA).

HCFA promised greater vigilance in such cases in response to an HHS Office of Inspector General study of 227,900 Medicare beneficiaries who disenrolled from six HMOs from 1991 through mid-1996. The study found that Medicare paid hospitals $90 million for total services received by the disenrollers during the first month after leaving their plans, and $224 million within three months.

That compares with only $20 million that Medicare would have paid in capitation payments for the same beneficiaries during the three-month period, had they remained in their plans, the OIG study notes.

Two cases cited in the OIG study:

A beneficiary "enrolled in the same HMO for six years" disenrolled in June 1992 and was admitted to a hospital as a fee-for-service patient less than two months later, then re-enrolled in the same HMO on Oct. 1, 1992. Medicare paid $97,000 for the DRG 483 tracheostomy (except for face, mouth and neck diagnosis) the beneficiary received during the hospital stay—which continued until the beneficiary's discharge on Nov. 19, 1992, or about seven weeks after the beneficiary's re-enrollment date. Medicare capitation payments for the beneficiary during the fee-for-service period would have amounted to only $1,000.

A beneficiary who'd been an HMO member for more than two years disenrolled in August 1994 and

see DISENROLL page 4

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New teeth for Florida's fraud busters

MEDICAID from page 1

notice provision. "We invite people to come and look at our records."

Safeguards for providers require the agency to hold a peer review of records before final action is taken on suspicious claims. If no fraud is found, the agency will pay the disputed amount with interest within 21 days. Interest will be accrued from the date of the claim suspension.

"The general public is as concerned as we are in government," said King-Shaw about Medicaid fraud. Billing for services and products not provided and unnecessary medical tests are just two areas where investigators are focusing their attention, officials say.

Investigators who have "enough claims information" can stop payment on claims, King-Shaw said, but the definition of suspicious claims is still unclear to some.

Overall, Fields said he supports the bill and is pleased to see the peer review provision added, but he would like a clearer definition of "suspicious" claims. Fields also said that requiring health insurers to move to electronic billing will be more cost-effective in the long run.

Fight fraud, but hurry it up

Physicians fed up with colleagues who cheat the system are also bristling from Medicaid's slow payments. Mas G. Massoumi, M.D., an orthopedic hand surgeon with Palm Beach Orthopedic Hand Center, P.A., in West Palm Beach, said "I have no dispute with the [new] law. These people don't deserve to be called doctor, provider or human being."

Massoumi, who used to see many more Medicaid patients before the price of X-rays went up in the 1980s, said he does have a dispute with how the fee schedule is laid out.

"Medicaid administrators are participating in fraud," Massoumi said. "They drag their feet for various reasons, then send you a statement indicating 'This claim is more than one year old and cannot be processed.'"

"It takes you a year to fight this, and even if you win," you have to spend more of your staff's time to collect what they pay you, he said.

"The current Medicaid fraud bill is only a band-aid on a wound which requires radical surgery," said Massoumi, who has practiced medicine for 25 years. "We cannot address the problem with health care in our state or our nation, unless we control the cost of delivery of the service."

King-Shaw

According to Bob Maryanski, Medicaid program administrator for the AHCA, the agency has made great strides in the last four years to stretch its dollar. In home health care, where the agency said the majority of health care fraud in Florida occurs, utilization and expenditures have been brought down 35 percent. The savings came after the agency implemented prior authorization restrictions to businesses, based on medical necessity.

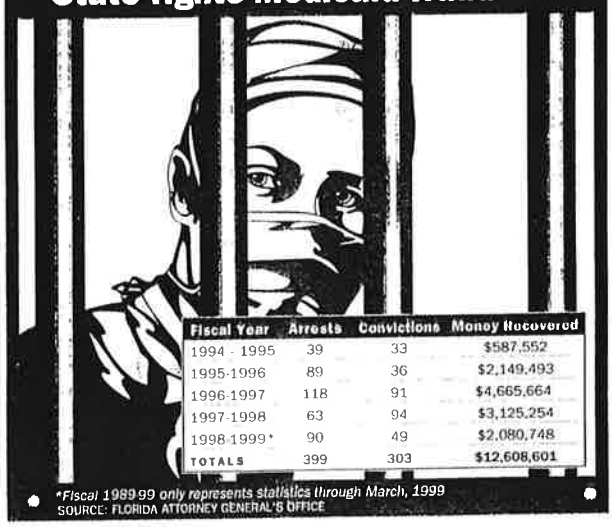
AHCA initiatives such as provider surety bonding, additional system edits, on-site inspections prior to provider enrollment and improved detection software, also has reduced spending by more than $100 million annually.

To improve the AHCA's efforts in recouping funds from fraudulent offenders, the measure will also:

- Require health insurance entities to use standard tape or electronic billing format adopted by the agency
- Create an "Estate Recovery Act" that will improve the agency's ability to recover Medicaid payments from estates of recipients
- Require HMOs to provide records and information to the AHCA for the purpose of recognizing potential coverage for claims filed with the agency.

"We are not out to destroy businesses," King-Shaw said. The agency wants to ensure that "taxpayers' money is well spent." ◆

• State fights Medicaid fraud •



Fiscal Year	Arrests	Convictions	Money Recovered
1994 - 1995	39	33	$587,552
1995-1996	89	36	$2,149,493
1996-1997	118	91	$4,665,664
1997-1998	63	94	$3,125,254
1998-1999*	90	49	$2,080,748
TOTALS	399	303	$12,608,601

*Fiscal 1998-99 only represents statistics through March, 1999
SOURCE: FLORIDA ATTORNEY GENERAL'S OFFICE

Agency implements Arthur Anderson's recommendations

In an effort to knock out health care fraud and keep funds in the program, the AHCA contracted with the accounting and consulting firm Arthur Andersen in July, 1998. The group was hired to assess Florida's Medicaid drug fraud and abuse program and develop a strategic plan for enhancing Florida's initiatives. The final report, which contained 123 recommendations, was sent to the state in December. One recommendation, adopted by the agency in May, began requiring pharmacies to include provider information on the drug claim.

Over the next few months, the state Medicaid program will implement several more of Andersen's recommendations, including:

- Establishment of a provider network tracking system.
- Enhancement of pharmacy inventory reporting requirements.
- Implementation of Consultec on July 1, 1999 to improve system edits.
- Restructuring of the Prospective Drug Utilization Review (ProDUR) system.
- Enhancement of fraud detection software and implementation of data warehouse system.
- Implementation of a new Surveillance and Utilization Review System (SURS) to detect aberrant billing patterns.