Approved: 3-6-96
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 22, 1996 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Carla Stovall, Kansas Attorney General
William W. Sneed, Legislative Counsel, Health Insurance Association of America
Jerry Slaughter, Executive Director, Kansas Medical Society
Tom Bell, Kansas Hospital Association
Alice Hamilton Nida, Director of Elder Rights, Kansas Department on Aging
John Badger, Chief Legal Counsel, Department of Social and Rehabilitation Services
Dawn L. Reid, Assistant Director, Kansas State Nurses Association

Others attending: See attached list

Hearing on SB 660 - Kansas medicaid fraud control act

Carla Stovall, Kansas Attorney General, testified in support of **SB 660** noting that this legislation would provide essential legal tools in their efforts to combat Medicaid provider fraud. She noted that this epidemic of fraud, according to the General Accounting Office, steals 10% of the more than one trillion dollars in health care costs that this country annually spends. For Kansas, with a Medicaid budget of more than eight hundred million dollars, translates to eighty million dollars (30.3 million dollars in state general funds) that are at risk of being diverted from the patients who need such care and the honest providers who deliver such care. It was pointed out that the bill will provide the specific legal tools to make maximum use of both personnel and fiscal resources.

Martha Hodgesmith, Assistant Attorney General, briefed the Committee on proposed amendments to the bill that were recommended by the Attorney General's office. During Committee discussion, Ms. Hodgesmith also gave examples of some of the cases concerning medicaid fraud. Included with the balloon of the bill showing the proposed amendments, Ms. Hodgesmith also provided the Committee with various documents and brochures from the Office of the Attorney General's Medicaid Fraud and Abuse Division. (Attachment 1)

Bill Sneed, Health Insurance Association of America, testified in support of **SB 660** and noted that the bill is a comprehensive bill for which a variety of groups have provided input. (Attachment 2)

Jerry Slaughter, KMS, expressed his support for the concept of **SB 660** and stated that while KMS supports vigorous fraud enforcement, they also believe it should be balanced and fair to providers. It was also pointed out that if providers perceive this new fraud initiative as over-reaching, or if is has the potential of putting them at risk for prosecution because of inadvertent mistakes in billing, it would further discourage their participation. (Attachment 3)

Tom Bell, KHA, testified that his organization is supportive of legislation intended to control Medicaid fraud in Kansas, but at the same time would be remiss if they did not look at this legislation with a critical eye to determine whether it presents any practical problems for health care providers in the state. Mr. Bell noted that most of the language in **SB 660** is already contained in federal Medicare and Medicaid law, and it is his hope that the Attorney General's Medicaid Fraud and Abuse division can work together with federal authorities to share information and resources so that both branches of government can operate as efficiently as possible. (Attachment 4)

Alice Nida, KDA, expressed her support for the bill and noted that while SRS has done a good job of cutting excess payments out of Medicaid, they support the efforts of the AG in exposing Medicaid fraud and in penalizing medical providers that steal from older Kansans and Kansas taxpayers. (Attachment 5)

John Badger stated that although SRS has investigated allegations of Medicaid fraud and abuse for many years, it has sometimes been difficult to find a prosecutor with sufficient expertise in this area of the law who is willing to file charges. The new Medicaid Fraud Control Unit will be a specialized unit with the necessary expertise, and the bill will provide the unit an important tool to use in successfully prosecuting these cases. (Attachment 6)

Dawn Reid, Assistant Director, Kansas State Nurses Association, noted that while she supports the intent of the bill, she also recommends the need for the establishment of a state medicaid fraud control unit and the need for protection for those reporting the fraud. It was pointed out that protection from actions such as retaliatory discharge, dismissal, demotion, suspension or other discriminatory type actions, including blacklisting, must include reinstatement of position, payment of back wages, full reinstatement of fringe benefits and actual damages. (Attachment 7) During Committee discussion it was noted that the Attorney General has stated her support for whistleblower protection, and that another Senate bill, **SB 474**, would be amended to provide protection to public agencies and public contractors, as well as providing remuneration for damages incurred by the whistleblower.

Reschedule

Due to the lack of time, the Chair announced that the hearing on **SB 680** would be rescheduled.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 23, 1996.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-22-96

NAME	REPRESENTING
John Peterson	K2 Governmental Consulting
HAROLD PITTS	AARP - KCOA
Jim McCann	AARP
Jim Ashworth	KECH
Dick Guthrie	Health Midwest
Marty Yost	Ks Health Care Assn.
Joyce E. Byrd	Shawnee County Council on Aging
Mary Ellen Conlee	Via Christi Health System
John Bolger	SRS
Sharon Bolyard	SRS
KEVIN LOESKE	CWA
[illegible]	CWA
[illegible]	CWA
[illegible]	CWA
Sandy Steinlicht	CWA
Katharine Poltkill	CWA
Marla Myers	Medical Assoc. Div. - Att. Gen.
[illegible]	Medical Assoc. Div. - Att. Gen.
Angela D. Laughlin	Diversified

Melissa Wangemann Hein Eberts & Assoc

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2/22/94

NAME	REPRESENTING
Mary Spinks	Dept of Admin - Personnel Sys
Sgt Bivens	Dept of Admin - DPS
Meg Henson	KS Medical Society
Jeffrey Shaffer	KTMA
Jason Pitzenberger	Brad Smoot

State of Kansas
Office of the Attorney General
MEDICAID FRAUD AND ABUSE DIVISION
700 S.W. JACKSON, SUITE 804, TOPEKA 66603-3758

CARLA J. STOVALL
ATTORNEY GENERAL

MAIN PHONE: (913) 368-6220
FAX: (913) 368-6223

SB 660
KANSAS MEDICAID FRAUD CONTROL ACT
SENATE PUBLIC HEALTH AND WELFARE
FEBRUARY 22, 1996

Senator Praeger and members of the Committee. Thank you for the opportunity to discuss SB 660 - the Kansas Medicaid Fraud Control Act; legislation that I believe will provide essential legal tools to my office in our efforts to combat Medicaid provider fraud. Although the vast majority of health care providers are honest and dedicated to providing the highest quality health care to their patients, Medicaid provider fraud costs American taxpayers hundreds of millions of dollars nationwide and tens of millions in Kansas annually and threatens the very integrity of the national and Kansas Medicaid programs.

AARP testimony to Congress in the fall of 1995 on the impact of fraud in the health care system emphasizes why we are here today on this bill, "Left unaddressed, fraud and abuse within the health care system will have a corrosive effect throughout the system and on the public's view of government stewardship generally." Through the enactment of this bill the Legislature can join with me on the "front lines" of the battle to fight this epidemic of fraud from further infecting the Kansas Medicaid program.

This epidemic, according to the General Accounting Office, STEALS 10% of the more than ONE TRILLION DOLLARS in health care costs that this country annually spends. For Kansas, with a Medicaid budget of more than EIGHT HUNDRED MILLION DOLLARS, this translates to EIGHTY MILLION DOLLARS (30.3 MILLION DOLLARS IN STATE GENERAL FUNDS) that are at risk of being diverted from the patients who need such care and the honest providers who deliver such care.

In August, 1995, Governor Graves joined me in submitting an application to the Department of Health and Human Services for certification and funding of the Medicaid Fraud and Abuse Division within the Office of the Attorney General. In October, 1995, the Division was certified, and Federal funding, at a match rate of 90% of total funds, was authorized. Attached to this testimony is a description of the Division and the performance standards to which all Fraud Control Units are held.

The Division's staff brings years of experience in criminal prosecution, fraud investigation, accounting and auditing, and expertise in public and private health care programs. Federal funding at the 90% level supports their efforts to have the investigative and prosecutorial resources to pursue complex, information intense, time consuming cases.

SB 660 will provide the specific legal tools to make maximum use of both personnel and fiscal resources. False claims, false statements, false representations, intentional failure to maintain records, kickbacks, and bribes are among the acts that are prohibited. Conviction of these crimes subjects fraudulent providers to general and special criminal penalties as well as payment of full restitution, payment of interest on the amounts of restitution, and payment of all reasonable expenses incurred in

Senate Public Health and Welfare
Date: 2-22-96
Attachment No. 1

the enforcement of the act.

In drafting this bill my office did an extensive survey of State and Federal statutes in this area, consulted with other States' Medicaid Fraud Control Units and Federal prosecutors on their experience in using such laws, and consulted with representatives of Kansas Medicaid providers. Subsequent to the bill's introduction, my staff has worked to develop a set of amendments that you have before you. These amendments reflect my commitment to making the law as clear as possible for those who have the responsibility to comply with the law. I believe that will be accomplished by the amendments as follow:

1. Delete New Section 4 on page 4, Lines 17-43 and Page 5, lines 1-7.

   CURRENT CRIMINAL STATUTES IN KANSAS ADEQUATELY DESCRIBE THE LEVEL OF INTENT REQUIRED FOR CONVICTION. THUS, PROVIDING CLEAR GUIDANCE AS TO WHAT CONSTITUTES A VIOLATION OF THIS ACT.

2. Kickbacks -- Add subsection (c) to New Section 5.

   NEW SUBSECTION (C) ESTABLISHES AN EXCEPTION TO THE ANTI-KICKBACK STATUTE FOR BUSINESS PRACTICES THAT ARE CONDUCTED IN THE ORDINARY COURSE OF BUSINESS AND ARE APPROPRIATELY REFLECTED IN THE CLAIMS OR REPORTS SUBMITTED TO THE KANSAS MEDICAID PROGRAM.

3. Record Keeping and Statute of Limitations --
   New Section 6, Page 5, Lines 41-43; New Section 7, Page 6, lines 13 and 14, New Section 10, Page 8, line 18, and New Section 15, Page 9, Line 42.

   THESE CHANGES REDUCE THE STATUE OF LIMITATIONS AND RECORD MAINTENANCE REQUIREMENT TO FIVE YEARS. THIS TIME FRAME MATCHES SRS REQUIREMENTS FOR RECORD KEEPING.

4. Access to Records -- New Section 12, Page 8, Lines 41-43 and Page 9, Lines 1-3.

   THESE CHANGES CLARIFY ACCESS TO PROVIDER RECORDS BY THE OFFICE OF THE ATTORNEY GENERAL AND OUR RELIANCE ON GENERAL CRIMINAL PROCEDURE IN OBTAINING EVIDENCE.

5. Inclusion in the Criminal Code

   THIS NEW SECTION PROPOSES THAT THIS ACT BE PART OF THE KANSAS CRIMINAL CODE.

Your adoption of these amendments and recommendation of favorable passage of the bill in its entirety insures a Kansas Medicaid Provider Fraud Control Act which clearly sets forth the ground rules to which all Medicaid providers will be held while creating a level playing field in which the spirit of competition can thrive without unfair advantage to those who will not play by the rules.

State of Kansas
Office of the Attorney General
MEDICAID FRAUD AND ABUSE DIVISION
700 S.W. JACKSON, SUITE 804, TOPEKA 66603-3758

CARLA J. STOVALL
ATTORNEY GENERAL

MAIN PHONE: (913) 368-6220
FAX: (913) 368-6223

SB 660
KANSAS MEDICAID FRAUD CONTROL ACT
SENATE PUBLIC HEALTH AND WELFARE
FEBRUARY 22, 1996

ATTACHMENTS

1. Senate Bill 660 with proposed amendments.

2. Brochure from the Office of the Attorney General Medicaid Fraud and Abuse Division.

3. Program standards for Medicaid Fraud Control Units, Federal Register, Volume 59, Number 185, published September 26, 1994.

4. National Association of Medicaid Fraud Control Units, A Review of the State Medicaid Fraud Control Unit program, Overview, published 1996.

SENATE BILL No. 660

By Committee on Public Health and Welfare

2-12

AN ACT enacting the Kansas medicaid fraud control act; declaring certain acts to be crimes and providing penalties therefor; authorizing civil actions and penalties for certain violations; granting certain powers to and imposing certain duties upon the attorney general; amending K.S.A. 21-3106 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. Sections 1 to 14, inclusive, and amendments thereto shall be known and may be cited as the Kansas medicaid fraud control act.

New Sec. 2. As used in this act:

(a) "Attorney general" means the attorney general, employees of the attorney general or authorized representatives of the attorney general.

(b) "Benefit" means the receipt of money, goods, items, facilities, accommodations or anything of pecuniary value.

(c) "Claim" means an electronic, electronic impulse, facsimile, magnetic, oral, telephonic or written communication that is utilized to identify a good, service, item, facility or accommodation as reimbursable to the Kansas medicaid program, or its fiscal agents, or which states income or expense and is or may be used to determine a rate of payment to the Kansas medicaid program, or its fiscal agent.

(d) "Fiscal agent" means any corporation, firm, individual, organization, partnership, professional association or other legal entity which, through a contractual relationship with the department of social and rehabilitation services and thereby, the state of Kansas, receives, processes and pays claims under the Kansas medicaid program.

(e) "Family member" means spouse, child, grandchild of any degree, parent, grandparent of any degree, brother, sister, half-brother, half-sister, uncle, aunt, nephew or niece, whether biological, step or adoptive.

(f) "Medicaid program" means the Kansas program of medical assistance for which federal, state or local moneys, or any combination thereof, are expended as administered by the department of social and rehabilitation services, or its fiscal agent, or any successor federal or state, or both, health insurance program or waiver granted thereunder.

(g) "Person" means any agency, association, corporation, firm, limited

liability company, limited liability partnership, natural person, organization, partnership or other legal entity, the agents, employees, independent contractors, and subcontractors, thereof, and the legal successors thereto, and any official, employee or agent of a state or federal agency having regulatory or administrative authority over the medicaid program.

(h) "Provider" means a person who has applied to participate in, who currently participates in, who has previously participated in, who attempts or has attempted to participate in the medicaid program, by providing or claiming to have provided goods, services, items, facilities or accommodations.

(i) "Recipient" means an individual, either real or fictitious, in whose behalf any person claimed or received any payment or payments from the medicaid program, or its fiscal agent, whether or not any such individual was eligible for benefits under the medicaid program.

(j) "Records" mean all written documents and electronic or magnetic data, including, but not limited to, medical records, X-rays, professional, financial or business records relating to the treatment or care of any recipient; goods, services, items, facilities or accommodations provided to any such recipient; rates paid for such goods, services, items, facilities or accommodations; and goods, services, items, facilities, or accommodations provided to nonmedicaid recipients to verify rates or amounts of goods, services, items, facilities or accommodations provided to medicaid recipients, as well as any records that the medicaid program, or its fiscal agents require providers to maintain.

(k) "Sign" means to affix a signature, directly or indirectly, by means of handwriting, typewriter, stamp, computer impulse or other means.

(l) "Statement or representation" means an electronic, electronic impulse, facsimile, magnetic oral, telephonic, or written communication that is utilized to identify a good, service, item, facility or accommodation as reimbursable to the medicaid program, or its fiscal agent, or that states income or expense and is or may be used to determine a rate of payment to the medicaid program, or its fiscal agent.

New Sec. 3. (a) Making a false claim, statement, or representation to the medicaid program is, knowingly and with intent to defraud, making, presenting, submitting, offering or causing to be made, presented, submitted or offered:

(1) Any false or fraudulent claim for payment for any good, service, item, facility, accommodation for which payment may be made, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable;

(2) any false or fraudulent statement or representation for use in determining payments which may be made, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable;

(3) any false or fraudulent report or filing which is or may be used in computing or determining a rate of payment for any good, service, item, facility or accommodation, for which payment may be made, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable;

(4) any false or fraudulent statement or representation made in connection with any report or filing which is or may be used in computing or determining a rate of payment for any good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable;

(5) any statement or representation for use by another in obtaining a good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program, knowing the statement or representation to be false, in whole or in part, by commission or omission, whether or not the claim is allowed or allowable;

(6) any claim for payment, for any good, service, item, facility, or accommodation, which is not medically necessary in accordance with professionally recognized standards, for which payment may be made, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable; or

(7) any wholly or partially false or fraudulent book, record, document, data or instrument, which is required to be kept or which is kept as documentation for any good, service, item, facility or accommodation or of any cost or expense claimed for reimbursement for any good, service, item, facility or accommodation for which payment is, has been, or can be sought, in whole or in part, under the medicaid program, whether or not the claim is allowed or allowable.

(b) Making a false claim, statement or representation to the medicaid program is knowingly making, presenting, submitting, offering or causing to be made, presented, submitted or offered, any wholly or partially false or fraudulent record, document, data or instrument to any properly identified law enforcement officer, any properly identified employee or authorized representative of the attorney general, or to any properly identified employee or agent of the department of social and rehabilitation services, or its fiscal agent, in connection with any audit or investigation involving any claim for payment or rate of payment for any good, service, item, facility or accommodation payable, in whole or in part, under the medicaid program.

(c) Making a false claim, statement or representation to the medicaid program is knowingly, making, presenting, submitting, offering or causing to be made, presented, submitted, or offered, directly or indirectly, any false or fraudulent statement or representation made to influence any

acts or decision of any person exercising any authority in the Kansas medicaid program.

(d) (1) As defined by subsection (a), making a false claim, statement or representation to the medicaid program where the aggregate amount of payments illegally claimed is $25,000 or more is a severity level 7, nonperson felony.

(2) As defined by subsection (a), making a false claim, statement or representation to the medicaid program where the aggregate amount of payments illegally claimed is at least $500 but less than $25,000 is a severity level 9, nonperson felony.

(3) As defined by subsection (a), making a false claim, statement or representation to the medicaid program where the aggregate amount of payments illegally claimed is less than $500 is a class A misdemeanor.

(4) As defined by subsections (b) and (c), making a false claim, statement or representation to the medicaid program is a severity level 9, nonperson felony.

New Sec. 4. (a) A person shall be deemed to have known that a claim, statement, representation, report, filing, book, record, document, data or instrument was false or fraudulent, if the person knew, or by virtue of the person's position, authority or responsibility had reason to know of the false or fraudulent nature of the claim, statement, representation, report, filing, book, record, document, data or instrument.

(b) A person shall be deemed to have made, presented, submitted, offered or caused to be made, presented, submitted or offered a claim, statement, representation, report, filing, book, record, document, data or instrument if the person:

(1) Had the authority or responsibility to:

(A) Make, present, submit, or offer the claim, statement, representation, report, filing, book, record, document, data or instrument;

(B) supervise another who made, presented, submitted, or offered the claim, statement, representation, report, filing, book, record, document, data or instrument; or

(C) authorize the making, presenting, submitting, or offering of the claim, statement, representation, report, filing, book, record, document, data or instrument, whether by operation of law, business or professional practice, office procedure; and

(2) exercised that authority or responsibility or failed to exercise that authority or responsibility and, as a direct or indirect result, the false or fraudulent claim, statement, representation, report, filing, book, record, document, data or instrument was made, presented, submitted or offered.

(c) A person shall be deemed to have made, presented, submitted, offered or caused to be made, presented, submitted or offered a claim, statement, representation, report, filing, book, record, document, data or

~~instrument if the person made, presented, submitted, offered or caused to be made, presented, submitted or offered the claim, statement, representation, report, filing, book, record, document, data or instrument, whether or not the person had the authority to make, present, submit, offer or cause to be made, presented, submitted, or offered the claim, statement, representation, report, filing, book, record, document, data or instrument.~~

New Sec. 5. (a) No person nor family member of such person shall:

(1) Knowingly and intentionally solicit or receive any remuneration, including but not limited to any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(A) In return for referring or refraining from referring an individual to a person for the furnishing or arranging for the furnishing of any good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program; or

(B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program.

(2) Knowingly and intentionally offer or pay any remuneration, including, but not limited to, any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person:

(A) To refer or refrain from referring an individual to a person for the furnishing or arranging for the furnishing of any good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program; or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, service, item, facility or accommodation for which payment may be made, in whole or in part, under the medicaid program.

(b) A violation of this section is a severity level 7, nonperson felony.

New Sec. 6. (a) Failure to maintain adequate records is negligently failing to maintain such records as are necessary to disclose fully the nature of the goods, services, items, facilities or accommodations for which a claim was submitted or payment was received under the medicaid program, or such records as are necessary to disclose fully all income and expenditures upon which rates of payment were based under the medicaid program. Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the medicaid program, a person shall maintain adequate records for 10 years after the date on which payment was received, if payment was received, or for 10 years after the date on which the claim was submitted, if the payment

(c) This section shall not apply to a refund, discount, or other reduction obtained by a provider in the ordinary course of business, and appropriately reflected in the claims or reports submitted to the medicaid program, or its fiscal agent.

8-1

was not received.

(b) Failure to maintain adequate records is a class A, nonperson misdemeanor.

New Sec. 7. (a) Destruction or concealment of records is intentionally destroying or concealing such records as are necessary to disclose fully the nature of the goods, services, items, facilities or accommodations for which a claim was submitted or payment was received under the medicaid program, or such records as are necessary to disclose fully all income and expenditures upon which rates of payment were based under the medicaid program. Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the medicaid program, a person shall not destroy or conceal any records for 10 years after the date on which payment was received, if payment was received, or for 10 years after the date on which the claim was submitted, if the payment was not received.

(b) Destruction or concealment of records is a severity level 9, nonperson felony.

New Sec. 8. (a) Repayment of payments, goods, services, items, facilities or accommodations wrongfully obtained shall not constitute a defense to or ground for dismissal of criminal charges or civil actions brought pursuant to this act.

(b) Evidence of repayment is inadmissible for any purpose during the trial of any action brought pursuant to this act.

New Sec. 9. (a) Any person convicted of a violation of this act, shall be liable, in addition to any other civil and criminal penalties provided by law, for all of the following:

(1) Payment of full restitution of the amount of the excess payments;

(2) payment of interest on the amount of any excess payments at the maximum legal rate in effect on the date the payment was made to the person for the period from the date upon which payment was made, to the date upon which repayment is made;

(3) payment of all reasonable expenses that have been necessarily incurred in the enforcement of this act, including, but not limited to, the costs of the investigation, litigation and attorney fees.

(b) All moneys recovered pursuant to subsection (a)(1) and (2), shall be paid and deposited in the state treasury and credited to the medicaid fraud reimbursement fund, which is hereby established in the state treasury. Moneys in the medicaid fraud reimbursement fund shall be divided and payments made from such fund to the federal government and affected state and local agencies for the refund of moneys falsely obtained from the federal, state and local governments.

(c) All moneys recovered pursuant to subsection (a)(3) shall be deposited in the state treasury and credited to the medicaid fraud prose-

cution revolving fund, which is hereby established in the state treasury. Moneys in the medicaid fraud prosecution revolving fund may be appropriated to the attorney general, or to any county or district attorney who has successfully prosecuted an action for a violation of this act and been awarded such costs of prosecution, in order to defray the costs of the attorney general and any such county or district attorney in connection with their duties provided by this act. No moneys shall be paid into the medicaid fraud prosecution revolving fund pursuant to this section unless the attorney general or appropriate county or district attorney has commenced a prosecution pursuant to this section, and the court finds in its discretion that payment of attorney fees and investigative costs is appropriate under all the circumstances, and the attorney general, or county or district attorney has proven to the court that the expenses were reasonable and necessary to the investigation and prosecution of such case, and the court approves such expenses as being reasonable and necessary.

New Sec. 10. (a) The attorney general may bring a civil action pursuant to this section against any person who violates this act.

(1) Any person who violates this act shall be liable, in addition to any other civil and criminal penalties provided by law, for all of the following:

(A) Payment of full restitution of the amount of the excess payments;

(B) payment of interest on the amount of any excess payments at the maximum legal rate in effect on the date the payment was made to the person for the period from the date upon which payment was made, to the date upon which repayment is made;

(C) payment of all reasonable expenses that have been necessarily incurred in the enforcement of this act, including, but not limited to, the costs of the investigation, litigation and attorney fees.

(2) Any person who violates this act may be liable, in addition to any other civil or criminal penalties provided by law, for all of the following:

(A) Payment of an amount equal to three times the amount of any excess payments;

(B) payment of a sum of not less than $5,000 nor more than $10,000 for each violation of this act.

(b) All moneys recovered pursuant to subsections (a)(1)(A), (a)(1)(B), (a)(2)(A), and (a)(2)(B) shall be deposited in the state general fund and credited to the medicaid fraud reimbursement fund. Moneys in the medicaid fraud reimbursement fund shall be divided and payments made from such fund to the federal government and affected state and local agencies in order to refund moneys falsely obtained from the federal, state and local governments.

(c) All moneys recovered pursuant to subsection (a)(1)(C) shall be deposited in the state treasury and credited to the medicaid fraud prosecution revolving fund. Moneys in the medicaid fraud prosecution re-

1-10

volving fund may be appropriated to the attorney general if the attorney general has successfully prosecuted an action for a violation of this act and has been awarded such costs of prosecution, in order to defray the costs incurred by the attorney general in connection with the discharging of duties provided by this act. No moneys shall be paid into the medicaid fraud prosecution revolving fund pursuant to this section unless the attorney general has commenced a prosecution pursuant to this section, and the court finds in its discretion that payment of attorney fees and investigative costs is appropriate under all the circumstances, and the attorney general has proven to the court that the expenses were reasonable and necessary to the investigation and prosecution of such case, and the court approves such expenses as being reasonable and necessary.

(d) A criminal action need not be brought against the person before civil liability attaches under this section.

(e) If recovery was made pursuant to section 9 and amendments thereto, recovery pursuant to this section is to be limited to subsection (a)(2).

(f) A civil action pursuant to this act must be commenced within ~~10~~ 5 years after the discovery of the violation of this act.

New Sec. 11. (a) There is hereby created within the office of the attorney general a medicaid fraud and abuse division.

(b) The medicaid fraud and abuse division shall be the same entity to which all cases of suspected medicaid fraud shall be referred by the department of social and rehabilitation services, or its fiscal agent, for the purpose of investigation, civil action, criminal prosecution or referral to the district or county attorney for criminal prosecution.

(c) In carrying out these responsibilities, the attorney general shall have all the powers necessary to comply with the federal laws and regulations relative to the operation of the medicaid fraud and abuse division, the power to investigate, bring civil action and criminally prosecute violations of this act, the power to cross-designate assistant United States attorneys as assistant attorneys general, the power to issue, serve or cause to be issued or served subpoenas or other process in aid of investigations and prosecutions, the power to administer oaths and take sworn statements under penalty of perjury, the power to serve and execute in any county, search warrants which relate to investigations authorized by this act, and the powers of a district or county attorney.

New Sec. 12. (a) The attorney general shall be allowed access to all records which are held by a provider, for the purpose of investigating whether any person may have violated this act, or for use or potential use in any legal, administrative or judicial proceeding pursuant to the Kansas Medicaid fraud control act.

~~(b) In carrying out the purposes of the Kansas medicaid fraud control act, the attorney general may take possession of records held by a provider~~

by subpoena, in which case copies of those records obtained by the attorney general which are necessary for the provider to continue doing business shall be supplied to the provider.

(b) (c) No person holding such records may refuse to provide the attorney general with access to such records on the basis that release would violate any recipient's right of privacy, any recipient's privilege against disclosure or use, or any professional or other privilege or right. The disclosure of patient information as required by this act shall not subject any provider to liability for breach of any confidential relationship between a patient and a provider.

Sec. 13. The provisions of this act are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy.

Sec. 14. If any section, subsection, paragraph or provision of this act shall be held to be invalid by any court for any reason, it shall be presumed that this act would have been passed by the legislature without such invalid section, subsection, paragraph or provision, and such finding or construction shall not in any way affect the remainder of this act.

Sec. 15. K.S.A. 21-3106 is hereby amended to read as follows: 21-3106. (1) A prosecution for murder may be commenced at any time.

(2) Except as provided by subsection ~~(6)~~ *(7)*, a prosecution for any of the following crimes must be commenced within five years after its commission if the victim is less than 16 years of age: (a) Indecent liberties with a child as defined in K.S.A. 21-3503 and amendments thereto; (b) aggravated indecent liberties with a child as defined in K.S.A. 21-3504 and amendments thereto; (c) enticement of a child as defined in K.S.A. 21-3509 and amendments thereto; (d) indecent solicitation of a child as defined in K.S.A. 21-3510 and amendments thereto; (e) aggravated indecent solicitation of a child as defined in K.S.A. 21-3511 and amendments thereto; (f) sexual exploitation of a child as defined in K.S.A. 21-3516 and amendments thereto; or (g) aggravated incest as defined in K.S.A. 21-3603 and amendments thereto.

(3) Except as provided in subsection ~~(6)~~ *(7)*, a prosecution for any crime must be commenced within 10 years after its commission if the victim is the Kansas public employees retirement system.

(4) Except as provided by subsection ~~(6)~~ *(7)*, a prosecution for rape, as defined in K.S.A. 21-3502 and amendments thereto, or aggravated criminal sodomy, as defined in K.S.A. 21-3506 and amendments thereto, must be commenced within five years after its commission.

(5) Except as provided in subsection (7), a prosecution for any crime found in the Kansas medicaid fraud control act must be commenced within 10 years after its discovery.

~~(5)~~ *(6)* Except as provided by subsection ~~(6)~~ *(7)*, a prosecution for any

crime not governed by subsections (1), (2), (3) ~~and~~, (4) *and (5)* must be commenced within two years after it is committed.

~~(6)~~ *(7)* The period within which a prosecution must be commenced shall not include any period in which:

(a) The accused is absent from the state;

(b) the accused is concealed within the state so that process cannot be served upon the accused;

(c) the fact of the crime is concealed;

(d) a prosecution is pending against the defendant for the same conduct, even if the indictment or information which commences the prosecution is quashed or the proceedings thereon are set aside, or are reversed on appeal;

(e) an administrative agency is restrained by court order from investigating or otherwise proceeding on a matter before it as to any criminal conduct defined as a violation of any of the provisions of article 41 of chapter 25 and article 2 of chapter 46 of the Kansas Statutes Annotated which may be discovered as a result thereof regardless of who obtains the order of restraint; or

(f) whether or not the fact of the crime is concealed by the active act or conduct of the accused, there is substantially competent evidence to believe two or more of the following factors are present: (i) The victim was a child under 15 years of age at the time of the crime; (ii) the victim was of such age or intelligence that the victim was unable to determine that the acts constituted a crime; (iii) the victim was prevented by a parent or other legal authority from making known to law enforcement authorities the fact of the crime whether or not the parent or other legal authority is the accused; and (iv) there is substantially competent expert testimony indicating the victim psychologically repressed such witness' memory of the fact of the crime, and in the expert's professional opinion the recall of such memory is accurate and free of undue manipulation, and substantial corroborating evidence can be produced in support of the allegations contained in the complaint or information but in no event may a prosecution be commenced as provided in this section later than the date the victim turns 28 years of age. Corroborating evidence may include, but is not limited to, evidence the defendant committed similar acts against other persons or evidence of contemporaneous physical manifestations of the crime. "Parent or other legal authority" shall include but not be limited to natural and stepparents, grandparents, aunts, uncles or siblings.

~~(7)~~ *(8)* An offense is committed either when every element occurs, or, if a legislative purpose to prohibit a continuing offense plainly appears, at the time when the course of conduct or the defendant's complicity therein is terminated. Time starts to run on the day after the offense is

1-13

committed.

~~(8)~~ *(9)* A prosecution is commenced when a complaint or information is filed, or an indictment returned, and a warrant thereon is delivered to the sheriff or other officer for execution. No such prosecution shall be deemed to have been commenced if the warrant so issued is not executed without unreasonable delay.

Sec. 16. K.S.A. 21-3106 is hereby repealed.

Sec. 17. This act shall take effect and be in force from and after its publication in the statute book.

New Section 18. This act shall be part of and supplemental to the Kansas criminal code.

members, and substantive program information.

Dated: September 15, 1994.

Margery G. Grubb,

Senior Committee Management Specialist, NIH.

[FR Doc. 94-23668 Filed 9-23-94; 8:45 am]

BILLING CODE 4140-01-M

Office of Inspector General

Performance Standards for State Medicaid Fraud Control Units

AGENCY: Office of Inspector General, HHS.

ACTION: Notice.

SUMMARY: In accordance with section 1902(a)(61) of the Social Security Act and the authority delegated to the Inspector General, this notice sets forth standards for assessing the performance of the State Medicaid Fraud Control Units. These standards will be used in the certification and recertification of each Unit and to determine if a Unit is effectively and efficiently carrying out its duties and responsibilities.

EFFECTIVE DATE: These performance standards are effective on September 26, 1994.

FOR FURTHER INFORMATION CONTACT:

Paul F. Conroy, Office of Investigations, (202) 619-3210

Joel Schaer, Legislation, Regulations and Public Affairs Staff, (202) 619-0089

SUPPLEMENTARY INFORMATION:

I. Background

Since the enactment of the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, authorizing the establishment and funding for Medicaid Fraud Control Units (MFCUs), 42 States have created such fraud control units to investigate and prosecute Medicaid provider fraud and patient abuse and neglect in Medicaid funded facilities.

A MFCU must be a single, identifiable entity of the State government composed of (i) one or more attorneys experienced in investigating or prosecuting civil fraud or criminal cases who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors; (ii) one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud, and (iii) a senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit. While the preference of the enabling legislation has been for the unit to investigate and prosecute its own cases on a Statewide basis, the legislative history recognizes that not all States are lawfully able to establish the MFCU to do so.

The State Medicaid agency is required to enter into an agreement with the MFCU to refer all suspected cases of provider fraud to the unit, and to comply with the unit's requests for provider records or computerized data that is kept by the Medicaid agency. To ensure that Medicaid overpayments identified by a MFCU in the course of its investigations are recovered, each MFCU is required either to undertake civil recovery actions or have procedures to refer overpayments for collection to other appropriate State agencies.

The HHS Office of Inspector General (OIG) is delegated the authority to certify and recertify the MFCUs to ensure that the units fully comply with the governing statute and with Federal regulations set forth in 42 CFR part 1007. As part of its recertification process, the OIG reviews the State fraud units' applications for recertification and may conduct on-site visits to the units to observe their operations. The OIG also collects and analyzes statistical data on the number and type of cases under investigation, the number of convictions obtained, and the amount of recoveries.

II. Use Of Performance Standards

Section 13625 of the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66, amended section 1902 of the Social Security Act by adding a new paragraph (a)(61) that establishes a Medicaid State plan requirement that, effective January 1, 1995, a State must operate a MFCU in accordance with standards to be established by the Secretary.

The OIG intends to use these performance standards in the certification and recertification of a Unit, as well as for assessing the effectiveness of a Unit during on-site reviews.

III. Standards For Assessing The MFCUS

In cooperation with the Units themselves, represented by a working group from the National Association of Medicaid Fraud Control Units, the OIG has developed twelve performance standards to be used in evaluating a Unit's performance. Each of the current Unit directors has concurred with the standards and accompanying requirements or indicators set forth below.

Performance Standards

1. A Unit will be in conformance with all applicable statutes, regulations and policy directives.

In meeting this standard, the Unit must meet, but is not limited to, the following requirements—

A. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.

B. The Unit must be separate and distinct from the single State Medicaid agency.

C. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.

D. The Unit must submit annual reports, with appropriate certifications, on a timely basis.

E. The Unit must submit quarterly reports on a timely basis.

F. The Unit must comply with the Americans with Disabilities Act, the Equal Employment Opportunity requirements, the Drug Free Workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

2. A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit employ the number of staff that were included in the Unit's budget as approved by the OIG?

B. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?

C. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?

D. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

3. A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit have policy and procedure manuals?

B. Is an adequate, computerized case management and tracking system in place?

4 A unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit work with the single State agency to ensure adequate fraud referrals?

B. Does the Unit work with other agencies to encourage fraud referrals?

C. Does the Unit generate any of its own fraud cases?

D. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. A Unit's case mix, when possible, should cover all significant provider types.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit seek to have a mix of cases among all types of providers in the State?

B. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?

C. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?

D. Are there any special Unit initiatives targeting specific provider types that affect case mix?

E. Does the Unit consider civil and administrative remedies when appropriate?

6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.

In meeting this standard, the following performance indicators will be considered—

A. Is each stage of an investigation and prosecution completed in an appropriate time frame?

B. Are supervisors approving the opening and closing of investigations?

C. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the Unit's monitoring of the following case factors and outcomes will be considered—

A. The number, age, and type of cases in inventory.

B. The number of referrals to other agencies for prosecution.

C. The number of arrests and indictments.

D. The number of convictions.

E. The amount of overpayments identified.

F. The amount of fines and restitution ordered.

G. The amount of civil recoveries.

H. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?

B. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?

C. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?

D. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?

B. Does the Unit provide program recommendations to single State agency when appropriate?

C. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. A Unit should periodically review its Memorandum of Understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.

In meeting this standard, the following performance indicators will be considered—

A. Is the MOU more than 5 years old?

B. Does the MOU meet Federal legal requirements?

C. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?

D. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. The Unit director should exercise proper fiscal control over the unit resources.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?

B. Does the Unit maintain an equipment inventory?

C. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. A Unit should maintain an annual training plan for all professional disciplines.

In meeting this standard, the following performance indicators will be considered—

A. Does the Unit have a training plan in place and funds available to fully implement the plan?

B. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?

C. Are continuing education standards met for professional staff?

D. Does training undertaken by staff aid in the mission of the Unit?

These standards may be periodically reviewed and discussed with the Units and other State representatives to ascertain their effectiveness and applicability. Additional or revised performance standards may be proposed when deemed appropriate.

Dated: September 16, 1994.

June Gibbs Brown,

Inspector General.

[FR Doc. 94-23692 Filed 9-23-94; 8:45 am]

BILLING CODE 4150-04-P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ID-050-406A-02]

Closure of Public Lands, Idaho; Notice

AGENCY: Bureau of Land Management; Interior.

ACTION: Closure of public roads and public land.

SUMMARY: Certain public land and roads in Camas County, Idaho, have been closed to all public use until further notice.

The emergency closure will protect the public from a number of potentially hazardous materials which were recently discovered in the abandoned mill at the Princess Blue Ribbon Mine.

1-16

MEDICAID FRAUD AND PATIENT ABUSE

A REVIEW

of the

STATE MEDICAID FRAUD CONTROL UNIT PROGRAM

National Association of Medicaid Fraud Control Units
444 N. Capitol Street, Suite 339, Washington, D.C. 20001

1-17

OVERVIEW

"At the close of a long Congressional debate in 1965 over a bill assuring medical care for the aged, a hastily written measure was tacked on to deal with health care for the poor. The legislative 'sleeper' was quickly approved. Within the next fifteen years, the so-called sleeper, known as Medicaid, mushroomed into a vast, ambitious and controversial Federal and State program..."

– Bernard Weinraub
Special to the New York Times
April 6, 1981

The history of the state Medicaid Fraud Control Unit (MFCU) program is the story of a highly effective, federally funded state-based law enforcement presence[1] entrusted with the responsibility of ridding the nation's $130 billion[2] Medicaid program of fraud and nursing home abuse. Since the inception of this pioneering national program in 1978, the 47 state Medicaid Fraud Control Units[3] have obtained an impressive record of over 7,000 convictions, recovered hundreds of millions of dollars in restitution, and perhaps even more important than any specific prosecution or recovery, demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments. In addition to vigorously pursuing corrupt Medicaid providers, the Units investigate and prosecute violations of all state laws pertaining to fraud in the administration of the Medicaid program. The Units are further responsible for reviewing complaints of patient abuse and neglect in all residential health care facilities that receive Medicaid funds, and are justly proud of their accomplishments in protecting the most vulnerable of our population, the frail elderly who reside in nursing homes.

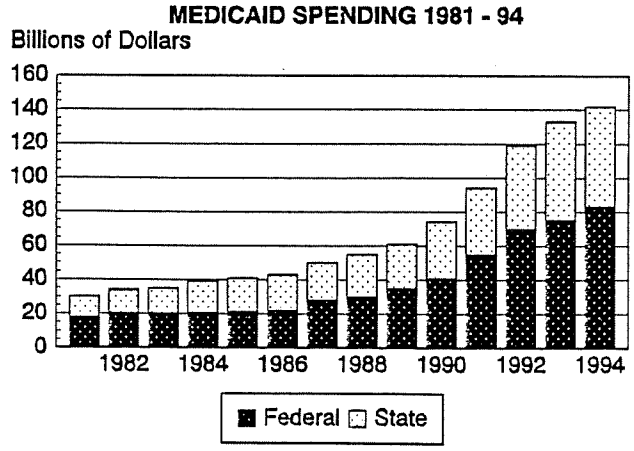
The need for the MFCUs came about when the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and other dishonest health care practitioners who saw fit to use the Medicaid program as their own private "money machine". To better understand how such a scandalous situation could have developed, one has to first look at the Medicaid program.

THE MEDICAID PROGRAM

Medicaid[4] was enacted by Congress in 1965 to provide a comprehensive range of medical services to both the disabled and America's poorest citizens. It is sometimes confused with Medicare[5], the federal health insurance program for persons 65 years of age and older. However, unlike Medicare, which is federally funded and provides the same benefit coverage throughout the United States, Medicaid is financed by federal and state funds[6] and is administered by each state. In addition to all 50 states, the District of Columbia and the territories participate in the Medicaid program.[7]

To become a participant in the Medicaid program, a state must meet certain federal standards, including the provision of selected minimum medical services and the designation of a single agency within each state to administer the program. States have the option of choosing to provide additional health care services to qualified Medicaid recipients. Each state, then, is unique by virtue of its own list of Medicaid-insured services it provides. Some states choose to provide chiropractic and podiatric services in their Medicaid packages, for example, while others might opt to include payment for prosthetic devices or hospice care services.

Though Medicaid benefits might differ from state to state, one common theme that has plagued the program since the mid-60s has been the skyrocketing costs to both state and federal budgets. Rocked by its own double-digit inflation in almost every year, the Medicaid price tag has risen from $3.9 billion in 1968 to over $130 billion in 1993. The reasons are numerous: increased enrollment, rising costs of medical care, the frequency with which the services are used, added services, and our aging population. Though most of these taxpayer dollars go directly toward providing needed medical care for the intended beneficiaries, a tremendous amount of money is lost to fraud and abuse.



Source: GAO Report, Medicare and Medicaid: Opportunities to save program dollars by Reducing Fraud and Abuse, Statement of Sarah F. Jaggar, Director, Health Financing and Policy Issues, Health, Education and Human Services Division, March 11, 1995, p. 3.

1-19

A PROGRAM OF MEDICAID FRAUD CONTROL

Regrettably, Congress failed to provide safeguards in the Medicaid program, thus giving a small, but greedy group of health care providers a free run to steal millions of taxpayer dollars during Medicaid's first decade of operation. Functioning with few controls to prevent fraud, and without any specific state or federal law enforcement unit responsible for monitoring criminal activity in the program, annual Medicaid expenditures by the mid-1970s had already begun their upward spiral (reaching $15 billion in 1976). If there was any question that fraud and mismanagement were hidden in this rapid cost increase, those doubts were put to rest as Congress conducted hearings and documented evidence of widespread misappropriation of taxpayer funds by a handful of unscrupulous health care providers. Under the leadership of Senators Frank Church, of Idaho, and Frank E. Moss, of Utah, the United States Senate Special Committee on Aging Subcommittee on Long-Term Care sounded the alarm. Focusing on California, New Jersey, Michigan, Illinois, and New York, which together accounted for more than 50 percent of the Medicaid purse, the Committee and its staff conducted hearings and documented evidence of widespread fraud in nursing homes, clinical labs, and other Medicaid and Medicare providers.

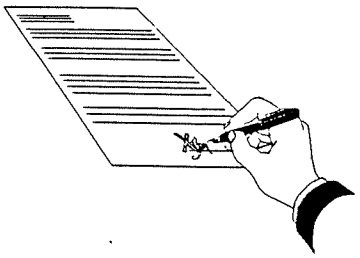
While numerous Congressional hearings were bringing such abuses to light, it became painfully obvious that where a separate statewide investigative entity had been established, such as in New York, the rate of prosecutions and convictions substantially increased along with the recovery of taxpayer dollars. For example, from 1970 to 1975, there was not a single prosecution in New York State for Medicaid fraud arising out of the operation of a nursing home. In January 1975, following revelations of widespread and shocking abuses plaguing that state's nursing home industry, New York appointed an independent special prosecutor, Charles J. Hynes, to investigate and prosecute those engaged in health care fraud and abuse.[8] That office quickly obtained convictions against two of the nation's most notorious nursing home operators, Bernard Bergman and Eugene Hollander, names that became synonymous nationwide with nursing home abuses. In its first 2 years, the Special Prosecutor's Office convicted more than 50 nursing home owners and operators and recovered millions of dollars in restitutions and fines. It was apparent that the crimes of Bergman and Hollander were visible examples of a systemic pattern of fraud.

Testifying before several Congressional committees, Special Prosecutor Hynes stated that while health care fraud was a problem of major proportions, very little had been done since most state prosecutors neither had the time nor the resources to deal with the highly complex crimes of health care fraud. He outlined an innovative framework, patterned after his office, of federally funded state fraud units staffed by coordinated teams of specialists — i.e., attorneys, investigators, and auditors — solely dedicated and trained in the prosecution of health care fraud and patient abuse cases. The Units would be separate and distinct from the single state agency that administered the Medicaid program in order to maintain their investigative independence and have statewide prosecutorial authority or the ability to establish formal procedures with the appropriate prosecuting authorities.

PUBLIC LAW 95-142

"The overwhelming majority of doctors and nursing home administrators are honest, patriotic and deeply dedicated to giving good health care according to the law and in the best interests of their patients, and we want to make sure that they who are honest can have a more efficient means by which they can patrol or monitor their own professions."

– *President Jimmy Carter*
October 25, 1977



Other states, too, were beginning to suffer the effects of unscrupulous health care providers. Michigan, Louisiana, Maine, Wisconsin, Kentucky, Massachusetts, Ohio, California, New Jersey, Illinois, and Pennsylvania joined the initial call for help. Using the New York Special Prosecutor's Office as its model, Congress responded, boldly and wisely, by passing Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). In signing the bill on October 25, 1977, President Jimmy Carter signaled a major commitment on the part of the federal government by providing each state with the opportunity and resources[9] to establish a Medicaid Fraud Control Unit to investigate and prosecute provider fraud and misconduct in the administration of the Medicaid program.

One year later — in October 1978 — nineteen MFCU directors formally met for the first time in Mt. Laurel, New Jersey, in conjunction with the inaugural national training conference for Medicaid Fraud Control. This meeting represented a giant step in the country's efforts to fight Medicaid fraud and abuse and, more importantly, to grapple with spiraling health care costs. The directors met with key staff of the then-U.S. Department of Health, Education & Welfare (HEW)[10] to discuss regulations, criteria for Unit certification and recertification, and other matters of mutual concern. It was at this meeting that Unit directors recognized the necessity to form a national association.

Formal organization of the National Association occurred 2 months later at Secretary of HEW Joseph Califano's National Conference on Fraud, Abuse & Error in Washington, D.C. Unit directors from 20 certified states met to elect a president and to form an executive committee which would ensure that all states were given equal input and representation in this young association — the National Association of Medicaid Fraud Control Units (NAMFCU). The aims of NAMFCU were to provide a forum for a nationwide sharing of information concerning the problems of Medicaid fraud and to develop the most effective means to contain such fraud. Charles J. Hynes, New York, was elected president, and regional representatives from Massachusetts, New Jersey, Alabama, Ohio, Colorado, and California were elected to the first executive committee. Further, the broad objectives of the association were crafted at that meeting.[11]

THE "BULLS AND BEARS" OF MEDICAID'S BLACK MARKET

"As a business, health care fraud and abuse would easily make the Fortune top 10."

– *"High Performance Computing and Advanced Transaction Analysis for Fraud Detection and Mitigation" (excerpt from a 1993 Booz-Allen & Hamilton chart)*

Public Law 95-142 came none too soon. Shadowing the rising number of young, urban professionals on Wall Street in the early '80s was a foreboding new trend in the Medicaid program, one which presented a serious challenge to both the MFCUs and the integrity of the program. In Pennsylvania, Maryland, Delaware, Massachusetts, Wisconsin, Michigan, New York, and New Jersey, Units were running up against Medicaid profiteers who were more entrepreneurial in their schemes than their nursing home predecessors. Like their Wall Street counterparts, these "bulls and bears" often were just as cognizant of the fluctuation of the dollar and price of precious metals on national and overseas markets as they were of Medicaid reimbursement rates.

In 1979-1980, for instance, as silver futures tripled in price on the New York Commodities Exchange, X-ray photographic film was considered a hot item on the medical black market. It had become very lucrative to extract the silver from X-ray film and leftover developing solutions — which could then be purified into silver needles and ingots of very high "four nines" (99.99 percent) purity and resold. As silver futures went on a wild roller coaster ride during this period, silver reclamation firms around the country literally became the dumping ground for hundreds of thousands of tons of new and used hospital X-ray film.

In essence, the way the silver skimming scheme worked was that hospital employees responsible for the maintenance, purchase, or sale of their facility's X-ray film stock and related products would sell this property to reprocessing firms and, instead of turning the money over to the hospital to offset the cost of running the X-ray department, they would unlawfully keep the proceeds of the sales for themselves. In some cases, the proceeds totaled more than $7,000 - $10,000 a month. In fact, "silver fever" became so overwhelming at times that as speculators, overreacting to high inflation and such international crises as the Iranian seizure of American hostages, helped to push the price of silver up — reaching a record high of $50 an ounce in January 1980 — some hospital X-ray technicians took to selling film that was still actually part of patients' records.[12] Fortunately, like the silver mining towns in the Old West, this scam was eventually abandoned as prices for the precious metal plummeted and MFCU prosecutions intensified. At the Radiological Society of America Convention held in Dallas, Texas, in September 1980, a chief topic of conversation among those in attendance was the investigative work of the Medicaid Fraud Control Units. According to the owner of one silver reclamation company who attended the convention, the general consensus of opinion was that the MFCUs had made a great impact upon the nation's entire radiology industry, and had contributed in large measure to the "cleaning up" of abuses which existed in the hospital industry.

THE MID-1980s

By the mid-1980s, cases of fraud or abuse had been brought by the MFCUs which spanned the medical horizon from acupuncturists, adult homes, and anesthesiologists to shoe companies, social workers, and X-ray technicians. At the same time, 36 states with Medicaid Fraud Control Units were facing a new dilemma: the rise of a new breed of Medicaid profiteer in business for the sole and exclusive purpose of exploiting the Medicaid program with no interest in delivering real medical care to real Medicaid patients. Furthermore, the Units were discovering that violent crimes such as arson and possession of deadly weapons had became part and parcel of traditional white-collar larceny schemes and, whereas in the early 1980s program thefts generally ranged in the thousands of dollars, Medicaid frauds were now creeping toward the $1 million mark.

Another fundamental change observed by the MFCUs was the growing involvement in the Medicaid program of foreign nationals and recently naturalized citizens, some of whom were unwittingly victimized by criminals plying their health care schemes and others who were the perpetrators of huge fraudulent schemes. Within this latter group, many maintained close contact with their native countries, made frequent trips abroad, and had no meaningful ties other than financial, to the United States. These providers, possessed of a skewed vision of the "American Dream" and constantly in search of the next great loophole in the system, were responsible for a surging wave of Medicaid fraud in the 1980s that moved from pharmacies and clinics to orthopedic shoe vendors and podiatrists and, later in the decade, to sonograms and drug diversion. They became more ruthless and bold in their efforts to steal from the program, and appeared more inclined to accept the risks of being caught in a major rip-off because of their easy ability to flee the United States to their homeland enriched with thousands, even millions, of taxpayer dollars.

Illustrative of the difficulties encountered in dealing with such international criminals was a MFCU case against a Pakistani physician arrested on a fugitive warrant at Kennedy Airport by U.S. Customs officials after his return to the United States from Manchester, England, and Zurich, Switzerland, where he had secreted hundreds of thousands of dollars in Medicaid funds. Suspended from the Medicaid program in 1984 for unacceptable medical practices (and thereafter permanently disqualified from the program in 1989), the physician was charged with systematically looting over $1.4 of the $2.5 million in Medicaid funds he received for supposedly treating recipients at his clinic during his suspension and after his disqualification from Medicaid. At the time of his arrest, an airline luggage tag listed the physician's address in Gratley, United Kingdom. He also had in his possession both an American and a Pakistani passport. The Pakistani passport, issued in the name Shahid Masood, listed his home address as Pakistan, and his date of birth as November 1, 1942. His American passport, on the other hand, issued in the name Shahid Masud Siddiqui, listed his date of birth as June 1, 1943. He also had two current driver's licenses on him — one issued by New Jersey and the other New York.[13]

Changing immigration trends, coupled with the rapid influx of both legal and undocumented aliens that many states experienced during the 1980s, had a tremendous impact on the

Medicaid program. As a result, although the Units investigate and prosecute provider fraud, there have been cases when the discovery committed by recipients was uncovered during the course of an investigation. For instance, while investigating clinics in Southern California, that state's MFCU received numerous community complaints alleging large-scale fraud in both Supplemental Security Income (SSI) and Medicaid programs by Southeast Asians. Contacting various community social service groups, MFCU investigators learned that repeated efforts by these groups to educate and assist the refugees with their applications for social programs were being hampered by greedy community opportunists. Among the allegations:

- Pharmacy owners paid kickbacks to the clinic owners and doctors for referral of Medicaid prescriptions;

- Middlemen, acting as translators and drivers (transporters), formed relationships with private neighborhood medical clinics and/or doctors and attorneys to assist and coach refugees on how to fraudulently obtain SSI payments;

- Medicaid recipients paid a "kickback" by the clinic owner, doctor and/or driver for coming to the clinic or, in some instances, recipients merely sold their Medicaid "stickers" (the documentation needed by the doctor in order to bill Medicaid) to the clinic owner, doctor, or driver.

Although the primary focus of the MFCU's probe was Medi-Cal fraud involving clinics billing for services and prescriptions that were either unnecessary or never actually provided, the Unit was not only able to confirm what the local Social Security offices believed was occurring — that middlemen were coaching Southeast Asians on the maladies necessary to get SSI for psychological disability — but it also uncovered another scheme involving drug addicts incarcerated in the state correctional facility who were inappropriately receiving SSI payments. While MFCUs do not normally investigate allegations of SSI fraud, the California Medi-Cal Unit proceeded in a joint investigation with the U.S. Department of Health and Human Services' Office of Inspector General — who had received similar complaints — because of the link between SSI and Medicaid.[14] It was apparent that no other law enforcement organization, state or federal, had the resources to pursue these cases.

THE LATE '80s AND EARLY 1990s

Perhaps even more disheartening, however, is that in many of our nation's poorer areas, where quality health care for a single mother and her children is a scarce commodity, health care fraud is a growth industry. Unsavory providers formulated marketing enterprises for themselves and created thousands of "off the book" middle-management jobs in this country's flourishing

underground marketplace where, in exchange for cash kickbacks, they obtained the raw material needed to illegally bill the Medicaid program.

A prime example was the "blood salesmen" of the mid-1980s who combed ghetto neighborhoods purchasing "street" blood from Medicaid "mills" and junkies who were willing to sell their blood for as little as fifty cents a vial. Appearing like legitimate businessmen making their daily rounds of clients, each "blood salesman" would pick up 150 - 200 vials a day per depot — paying the collectors $25 for each vial repackaged with a phony lab test request form, forged physician signature, and bogus Medicaid recipient name and number — which was then illicitly sold to full-scale medical testing laboratories that would run the blood through testing machines to create a paper trail and consequently generate $2,000 in fraudulent Medicaid billings for every $10 pint of a junkie's blood.

So sophisticated was this fraud that the size of kickbacks paid to the assorted salesmen, consultants, and collectors fluctuated according to market factors such as current supply and demand for "street" blood, whether blood was accompanied by a Medicaid recipient's name, and whether the purported referring doctor actually worked at the address listed on the lab test order form. By 1988, this fraud scam had become so pervasive that *The New England Journal of Medicine* wrote about it after physicians working in the emergency room at Manhattan's Columbia-Presbyterian Medical Center reported treating patients with severe, life-threatening anemia who had arrived at the hospital depleted of half their blood supply.[15]

A major "blood trafficking" operation took place in New York, masterminded by a decertified doctor and former Medicaid provider — previously convicted by that state's MFCU for billing for services never provided — and his elderly father. Charged with stealing more than $3.6 million in Medicaid funds, this father-son team's elaborate empire extended from the dirty and dangerous blood-drawing depots they established in the Bronx, to "shell" management companies set up in Brooklyn to do nothing but buy, collect, and package illicit blood, to the full-scale medical testing laboratories in Queens and Long Island they controlled and billed through.[16]

For every loophole in the system the MFCUs close, the unscrupulous providers seem to find another enterprise. In the late 1980's, it was sonograms. Once again, the poor were the prime commodity needed to fuel the scam. Paid $10 apiece to submit to repeated and useless sonogram testing, so-called "ultrasound salesmen" would tote shopping bags full of sonograms to offices of various radiologists who, in turn, supposedly "read" them and thereafter billed Medicaid. Once reimbursed by the program, the radiologists would kickback approximately 70% of their total Medicaid billings to the referring sonographers, clinic owners, and salesmen.

In one incredible case, a New York cab driver hit the state Medicaid program for a $140,000, off-the meter ride by taxiing junkies from Harlem to his Queens apartment, where they would lie on the couch and, for a $10 payoff, allow an ultrasound technician to take multiple

sonograms using a portable machine. This particular case grew out of a sophisticated conspiracy by the owners of a Bronx-based radiology billing company, who were indicted for stealing $335,000 from the state, failing to report over $10 million in Medicaid reimbursement on income tax returns, and paying large cash kickbacks — up to 65% - 75% of their $10 million in total Medicaid billings — to clinic owners and "salesmen" like the Queens cab driver for steering ultrasound business to their firm. The two owners, using forged and fictitious names, mail drops, and answering services to hide their ownership, enrolled nine different "shell" companies in the Medicaid system so that state auditors would not detect the enormous extent of their Medicaid claims. All three cases resulted in convictions and substantial jail time.

At the close of the decade of the 1980's, the Medicaid Fraud Control Units were confronted with a more virulent strain of an old problem — drug diversion. In the early 1980's, drug cases in the Medicaid program generally involved pharmacists filling prescriptions with cheaper generic substitutes for the more expensive brand name drugs actually prescribed by physicians and then submitting false Medicaid reimbursement claims for the brand names.[17] While this once common side to drug diversion schemes has, for the most part, been eliminated, it did lead to a recent Delaware MFCU investigation and conviction of a Dover pharmacy and its pharmacist owner. In addition to substituting drugs, the Delaware investigation unearthed numerous other violations of pharmacy regulations including undocumented refills of prescriptions.[18]

Yet a massive investigation — dubbed "Project Mortar" — by the Illinois MFCU in the mid-1980s first alerted the nation to a fast-growing and ingenious fraud enterprise involving a vast network of unscrupulous Medicaid physicians, pharmacies, laboratories, and recipients engaged in the blatant diversion of prescribed controlled and/or noncontrolled drugs. At the time, the investigations were the largest ever — $28 million — prosecuted in the United States and resulted in the conviction of 78 defendants, court-ordered restitution of nearly $11 million, and substantial incarcerations of defendants. Furthermore, this investigation laid the framework for many similar state and federal investigations involving dealing of drugs and prescriptions on the black market. (See Chapter 3.)

Locating illegal proceeds of such massive financial crimes had become more complex. In California, for example, the MFCU prosecuted one of the largest durable medical equipment frauds ever, with an estimated $40 million loss to the Medicaid program. Program claims were filed with the Medi-Cal program for diapers and other incontinence supplies that were not needed, ordered, purchased, or delivered. The scheme involved 4 defendants using false information on applications to enroll 11 companies as Medi-Cal providers of medical supplies. Like the sonogram scams, these defendants hired salespersons, in this instance to collect Medi-Cal stickers from Medi-Cal beneficiaries. The stickers were then utilized to submit false claims for incontinence supplies provided to those beneficiaries. Prosecuted by the MFCU in federal court in Los Angeles, in cooperation with the U.S. Attorney's Office and the FBI, federal asset forfeiture laws were used to seize bank accounts, cars, and real property worth $3 million. Bank records were

obtained from Switzerland, Luxembourg, Spain, and Liechtenstein, and a civil lawsuit charging one of the defendants with fraud was filed in Liechtenstein, with the court there issuing a preliminary injunction freezing accounts containing $6 million. Recoveries thus far have totaled $1.7 million, with another $3.5 million tied up by the civil suit in Liechtenstein where the money was seized. There is nearly $10 million identified in other European accounts that has not yet been seized.[19]

A record-breaking grand jury probe into Medicaid fraud and patient abuse in Connecticut spanned the decade of the 1980s. While its demise did not herald the end of Medicaid fraud or patient abuse in the State of Connecticut's efforts to investigate such matters, the grand jury probe set a record that probably will not be broken. During its duration, the grand jury reviewed 150 cases, resulting in 50 cases being referred back to the Connecticut Department of Income Maintenance for administrative action and 40 resulting in arrest, of which most ended in criminal conviction. In addition, the arrests led to the recovery of nearly $1 million in fines ($473,224) and restitution ($509,388). Furthermore, the Department of Income Maintenance in Connecticut recovered $389,035 from cases referred to it for administrative action.

THE 1990'S AND BEYOND

"In a very real sense, the Medicaid Fraud Control Unit Program now fills a critical role in the surveillance and enforcement of this nation's health care industry, much as the IRS and SEC have long served as an integrity check on our taxing and securities systems"

– *Edward J. Kuriansky*
Director, New York MFCU
April 1, 1993

As we near the end of the century, it is apparent that Medicaid fraud has virtually weaved its way into every fabric of American society. In its most blatant and simplistic form, the fraud occurs when the lone health practitioner overbills for services allegedly performed or the unscrupulous recipient goes to various physicians for no other purpose than to obtain prescriptions for a laundry list of expensive pharmecuticals which can then be sold on the underground medical black market for cash. In perhaps its most insidious form, Medicaid fraud not only contributes to this nation's already monstrous narcotics problem by providing addicts with a taxpayer-funded means to obtain their drug of choice but annually robs our beleaguered Medicaid system of untold millions of sorely needed dollars. As Americans, we fall victim to the fraud not only as taxpayers but as consumers when we unsuspectingly go to a pharmacy that has bought diverted Medicaid drugs at a discount and unknowingly take medications that may have lost their potency, been improperly stored and handled, or even been subject to recall.

Moreover, like a pebble dropped in a pond, the farther the fraud ripples away from its source, the harder it becomes to detect. Consequently, and much like organized crime, many of

the illegal dollars siphoned from the program are funneled back into legitimate enterprises. They have, for instance, been used to finance private health care practices, buy residences in the tonier sections of towns, pay salaries of honest health care staff, and, with utter temerity, repay the government for school loans.

* * * * *

The dramatic decline in annual Medicaid expenditures to an individual or group of providers or the termination of abusive caregivers in the aftermath of the Units' enforcement activity is testimony to the success of the MFCU program and its national association. The following is but a small part of the MFCUs' extraordinary story of investigation and prosecution of fraud and abuse in the Medicaid program.

MEMORANDUM

TO: The Honorable Sandy Praeger, Chair
Senate Public Health and Welfare Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

DATE: February 22, 1996

RE: S.B. 660

Madam Chair, Members of the Committee: My name is Bill Sneed and I am here today on behalf of the Health Insurance Association of America (HIAA). HIAA is a group of approximately 300 health insurance companies which write nearly 80% of the private health insurance coverage in the United States today. We appreciate the opportunity to present our testimony in support of S.B. 660, the Attorney General's Medicaid Fraud Control Act.

Senate Bill 660 is designed to crack down on the problem of Medicaid fraud. It is a comprehensive bill for which a variety of groups have provided input. These affected groups met recently to express thoughts and concerns about the provisions of the bill. The Attorney General's Office considered these concerns and incorporated many of them into amendments to the bill.

HIAA applauds the Attorney General for creating a comprehensive legislative package to address the problem of Medicaid fraud in Kansas. We support her efforts in this area and respectfully urge your favorable action on S.B. 660.

Thank you for the opportunity to testify. Please feel free to contact me if you have any questions.

Respectfully submitted,

William W. Sneed

Senate Public Health & Welfare
Date: 2-22-96
Attachment No. 2

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 22, 1996

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 660; concerning Medicaid fraud enforcement

The Kansas Medical Society appreciates the opportunity to appear today on SB 660, which was introduced at the request of the Attorney General. The bill enacts broad new statutory authority for the Attorney General's office to conduct Medicaid fraud enforcement activities as part of a federally funded initiative.

We especially want to thank the Attorney General, and Martha Hodgesmith of her staff, for their willingness to discuss this legislation with us in advance of today's hearing. Because of the sweeping powers authorized in this legislation to investigate provider fraud in the Medicaid program, we have spent a great deal of time trying to analyze the impact of its provisions on physicians who participate in the program.

For the record, we abhor the notion of provider fraud in not only government programs, but all other health programs as well. Individuals and institutions who intentionally defraud these programs should be prosecuted to the full extent of the law. Especially in the Medicaid program where scarce tax dollars are used to provide care for the state's indigent population, fraud wastes limited resources and diverts necessary medical care away from those who often need it most. We support the Attorney General's effort to eliminate fraud in the Medicaid program, and pledge to work with her staff to see that providers are adequately informed about the new program.

While we support vigorous fraud enforcement, we also believe it should be balanced and fair to providers. The Medicaid program has been one of the most difficult health programs for physicians to deal with over the years. Reimbursement is very low (many physicians receive only 25-30% of their charges), it is administratively complex, and the rules are constantly changing. This makes the program unpopular with providers, which has created significant access problems in many areas of the state. If providers perceive this new fraud initiative as over-reaching, or if it has the potential of putting them at risk for prosecution because of inadvertent mistakes in billing, it will further discourage their participation. We know that is not what is intended, and to that end we have worked with the Attorney General's staff to identify several areas of the bill which we believe should be looked at further.

Senate Public Health and Welfare
Date: 2-22-96
Attachment No. 3

We appreciate the changes which have been suggested by the Attorney General to address some of the concerns raised by the provider community. We are still looking at the remaining parts of the legislation, but we are encouraged by the changes made thus far.

Efforts to eliminate fraud in the Medicaid program will be more successful if the state and the provider community work together. The overwhelming majority of providers who take care of Medicaid patients would never even think of defrauding the program, and they have no sympathy for those who do. We hope that when the final version of this legislation is passed, it will protect the rights of providers, while also resulting in tough, but fair, enforcement. We appreciate your consideration of our remarks.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

To: Senate Public Health and Welfare Committee
From: Kansas Hospital Association
Re: SB 660-Medicaid Fraud Control Act
Date: February 22, 1996

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 660. This proposal establishes a comprehensive set of new laws in Kansas aimed at defining, preventing and controlling medicaid fraud in Kansas.

Since the Medicaid Fraud and Abuse Division of the Attorney General's office was formed last year we have had numerous discussions with its representatives about problems in the Medicaid system and fraud that is perpetrated on that system by both providers and recipients. We are convinced that the overwhelming majority of contacts Kansas hospitals will have with this new office will be in the nature of assistance in prosecuting such fraudulent activities. That is why we are supportive of legislation intended to control Medicaid fraud in Kansas. At the same time, we would be remiss if we did not look at this legislation with a critical eye to determine whether it presents any practical problems for health care providers in our state. We have done that and presented many of those issues to the Attorney General in a recent meeting. We are hopeful that those issues can be resolved and we are committed to continuing a dialogue with that office to do so.

Most of the language in SB 660 is already contained in federal Medicare and Medicaid law. It is our hope that the Attorney General's Medicaid Fraud and Abuse division can work together with federal authorities to share information and resources so that both branches of government can operate as efficiently as possible.

Thank you for your consideration of our comments.

Senate Public Health & Welfare
Date: 2-22-96
Attachment No. 4

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-5955

TESTIMONY ON SB 660
by
Alice Hamilton Nida, Kansas Department on Aging
to the
Senate Health and Public Welfare Committee
February 22, 1996

My name is Alice Hamilton Nida, Director of the Elder Rights Division for the Kansas Department on Aging. Thank you for the opportunity to speak with you.

The Kansas Department on Aging supports Senate Bill 660 which allows the Attorney General to set up a Medicaid fraud control unit. We praise the Attorney General for her fight against fraud.

There are those who will tell you that there is no medical fraud in Kansas. That is not what Kansas consumers tell us. Consumers tell us that there are physicians who cut the toenails of almost all residents in nursing homes and bill Medicare outrageous amounts when most toenail cutting is not a reimbursable service under Medicare.

We believe that SRS has done a good job of cutting excess payments out of Medicaid, but we support the efforts of the Attorney General in exposing Medicaid fraud and in penalizing medical providers that steal from older Kansans and Kansas taxpayers.

We are confident that the program will recover more money than it spends.

The Department on Aging believes there is medical fraud in Kansas and we believe the Medicaid fraud control unit can do something about it.

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

Senate Committee on Public Health and Welfare
Testimony on SB 660 Pertaining to the Kansas Medicaid Fraud Control Act

February 22, 1996

Madam Chairman and Members of the Committee, I am John Badger, Chief Legal Counsel for SRS, thank you for the opportunity to testify on behalf of Secretary Chronister today concerning the Kansas Medicaid Fraud Control Act.

The Medicaid Fraud Control Unit located in the Office of the Attorney General was created in response to a federal mandate in order to provide a single, identifiable entity in the state which can investigate and prosecute Medicaid fraud. A partnership has been developed between SRS and the Office of the Attorney General to insure that all cases of potential fraud and patient abuse are investigated and if necessary pursued through criminal or civil remedies.

Because of this partnership, the department supports SB 660 which provides specific authority and legal basis for pursuit of fraudulent health care providers in the Medicaid program. This legislation will provide the Medicaid Fraud Control Unit statutory authority to pursue and prosecute Medicaid fraud as a specific crime and will serve as a deterrent for many providers who may be inclined to commit fraudulent activity when such controls are absent.

Although SRS has investigated allegations of Medicaid fraud and abuse for many years it has sometimes been difficult to find a prosecutor with sufficient expertise in this area of the law who is willing to file charges. The new Medicaid Fraud Control Unit will be a specialized unit with the necessary expertise, and SB 660 will provide the unit an important tool to use in successfully prosecuting these cases.

For these reasons it is respectfully recommended this committee act favorably on SB 660.

John Badger
Chief Legal Counsel
296-3967

KANSAS STATE NURSES ASSOCIATION

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731

913/233-8638 * FAX 913/233-5222

the Voice of Nursing in Kansas

Betty Smith-Campbell, M.N., R.N
President

Terri Roberts, J.D., R.N.
Executive Director

For more information:
Dawn L. Reid, LLM,JD,RN
Assistant Director
700 SW Jackson, Suite 601
913.233.8638
Topeka, KS 66603-3731
February 22, 1996

SB 660 Medicaid Fraud Control Unit

Chairperson Praeger and members of the Senate Public Health and Welfare Committee: My name is Dawn Reid, LLM,JD,RN, and I am the Assistant Director of the Kansas State Nurses Association (KSNA). I am here to testify in support of SB 660. I have two points that I would like to address: the need for the establishment of a state medicaid fraud control unit and the need for protections for those reporting the fraud.

KSNA represents the interests of 29,000 registered nurses in the state of Kansas. Of these 29,000, 1,079 are advanced practice nurses, such as Nurse Practitioners, Nurse Anethestists, Clinical Nurse Specialists, and Certified Nurse Midwives. Thus, the majority of registered nurses in the state who practice nursing, practice at a staff nurse level; these may include those who work in hospitals, offices, community health agencies or home health arenas. Because they work with providers and patients on a daily basis, they have access to knowing when fraudulent billing practices may be occuring and how it is being practiced. Examples of health care fraud being practiced on a daily basis abound. One example of fraud encountered by nurses was a physician known as the "minute man". This was a psychiatrist who would demand that his charts and patients be lined up at the nurses station when he made his rounds. He would spend approximately 60-90 seconds (as timed) with each patient (including writing orders and notes in the patient's chart), but bill for a 30 minute session costing $150 dollars. Other examples include; the physician who charges for cataract removal, when the patients have no cataracts; ordering an MRI for a hangnail removal; charging for injections of sterile water; and keeping psychiatric patients on suicide watch until their date of discharge (the hospital is able to charge a much higher fee). These are just a few examples of many types of fraud that nurses are aware of and encounter on a daily basis. Nurses are very knowledgable about how the system is manipulated, as well as how their patients illness can be used to profit from. Nurses have the potential for being very powerful oversights.

However, because most nurses may be dependent on their jobs in order to support themselves and their families, they hesitate to

Senate Public Health & Welfare
Date: 2-22-96
Attachment No. 7

report fraud for fear of retribution and retailiatory actions by their employers or providers. If a nurse is working in a rural area, there may be only one or two facilities where work is available. Reporting fraud may result in the end of finding any work within that geographic area or that specialty of nursing due to blacklisting. Thus, because of this very real fear, much fraud that occurs goes unreported.

Medicaid fraud, which is currently estimated as costing 3-10 percent of the total budget or 10 cents on every dollar spent, needs to be investigated and controlled. Health care services are being cut due to the increased cost of providing care. The money that can be saved by preventing, controlling and recovering the fraud that is perpetrated upon the health care system on a daily basis could be used to fund these needed services. We feel that the need for a unit specializing in Medicaid fraud and control to be estabished in Kansas is vital.

However, we also find that the need to provide adequate protections to those who report the fraudulent activity is just as vital. Protections from actions such as retaliatory discharge, dismissal, demotion, suspension or other discriminatory type actions, including blacklisting must include reinstatement of position, payment of back wages, full reinstatement of fringe benefits, actual damages. The attorney general has stated her support for this bill, and the need for whistleblower protections. While KSA 75-2973 addresses whistleblower protections, it is currently being amended in SB 474 to include public agencies and public contractors, as well as providing remuneration for damages incurred by the whistleblower. It is in fact, officially known as "the Whistleblower Act". We interpret that bill as providing adequate protections for nurses who suffer the consequences of reporting fraudulent activities of their employers. We support SB 660, but only if the changes that are being proposed in SB 474 to KSA 75-2973 are concurrently passed.

Thank you.

b:dlr/green/sb660

U.S. News & World Report

February 24, 1992

SECTION: U.S. NEWS; COVER STORY; Vol. 112, No. 7; Pg. 34

LENGTH: 4998 words

HEADLINE: Health care fraud

BYLINE: By Gordon Witkin; Dorian Friedman; Monika Guttman

HIGHLIGHT:
Up to $ 80 billion is stolen each year from taxpayers and insurers. Bolder scams arise all the time, and little is done to stop them

BODY:

White-collar "wilding," one regulator calls it -- an orgy of economic crime. As America's health-care bill spirals to an estimated $ 817 billion this year, it is attracting an ever more impudent and wily army of scam professionals. Experts now estimate that fraud and abuse in the health-care field cost somewhere between $ 50 billion and $ 80 billion each year -- a figure that dwarfs the estimated $ 5 billion lost through criminal fraud in the entire savings and loan debacle. And of course, consumers and businesses are paying for these health-care rip-offs in higher taxes and skyrocketing insurance premiums.

The thing that spooks insurers and federal regulators these days is that the scams are growing dramatically bigger, bolder and more sophisticated. "Previously, the usual situation was single-subject fraud, involving one doctor or supplier," said Assistant Attorney General Stuart Gerson. "Now we are encountering more cartel-type frauds." Florida, with its huge elderly population, is a hotbed of health fraud, especially around Miami. The Philadelphia region has also been host to a variety of unsavory schemes, as have New York, Texas, Arizona, California and Michigan.

Investigators stress that the overwhelming majority of physicians and other health-care providers are dedicated and honest. But it doesn't take many to steal a lot, argues Richard Kusserow, inspector general for the Department of Health and Human Services. "A welfare queen would have to work mighty hard to steal $ 100,000. Somebody in the [medical] practitioner or provider community can burp and steal $ 100,000."

Authorities worry, too, that shifts in health care are opening the door wider for fraud. A burgeoning movement to electronic claims filing is eliminating the paper trail that provided investigators with many of their best leads. And as more health care moves away from the hospital and into outpatient settings and homes, keeping an eye on it gets tougher. Finally, each new advance in medical technology presents a new forum for fraud. The result is an endless game of cat and mouse. "For every loophole in the system we close," says Edward Kuriansky, New York's special Medicaid-fraud prosecutor, "the voracious provider seems to find another." What follows is a look at some of the more ingenious and far-reaching new kinds of fraud.

ROLLING LABS

One of the hottest schemes involves so-called rolling labs that conduct unnecessary and sometimes fake tests on unsuspecting patients, while billing insurance companies or the government for the cost. Federal authorities allege that the biggest such operation took place in Southern California, masterminded by two Russian immigrant brothers, Michael and David Smushkevich. Investigators claim the Smushkeviches and 10 cohorts filed $ 1 billion in false claims, of which some $ 50 million was paid by government and private insurers. At its peak between 1986 and 1988, the operation involved 1,000 separate companies and 400 bank accounts worldwide, according to insurance-firm estimates.

Indictments allege that patients were solicited through "boiler room" telemarketing operations. Phone sales representatives offered comprehensive physical exams, including state-of-the-art diagnostic testing, at little or no fee to the patient. The tests were conducted at health clubs, retirement homes, mobile-home parks or shopping malls serviced by the rolling labs, and later at free-standing clinics. To Constance Otero of Irvine, Calif., and many like her, it all sounded legitimate. The woman on the phone was "such a personable lady that she sounded like my best friend," Otero recalls. Although Otero, then 65, wasn't feeling ill, after many phone calls, "given my age, I thought, 'what the heck.' " The two-hour exam at a Tustin, Calif., clinic in 1988 resulted in $ 7,500 in billings.

In order to work, the alleged scheme had to circumvent important health-insurance basics: Most policies provide little or no coverage for preventive tests. They cover only testing that is medically necessary for a specific, current illness. And most require patients to pay a portion of the fee -- usually 20 percent.

Investigators say patients were required to fill out medical-history forms that were used to later justify the "medical necessity" of the tests -- though many said they were not complaining about any symptoms. A battery of diagnostic tests would be performed, sometimes before the patient had been examined. The defendants then doctored the medical records with false facts designed to result in payment by the insurance company or the government, according to the charges.

A major break in the case came in mid-1987 when Dr. William Marr, who worked for Pacific Mutual Insurance, got a phone solicitation. Marr was promised a complete physical and was told there would be no charge to him. When he reported for the exam, Marr told investigators, he filled out a routine health-history form, but was asked nothing specific about his current health. After some tests, his insurance firm, Pacific Mutual, was billed for more than $ 7,500. The diagnoses on the claims included high blood pressure, diabetes, heart disease and cancer, but Marr claimed he suffered from none of these conditions. Eight months later, authorities, prompted by private insurers with other claims against the Smushkeviches, raided their boiler rooms, clinics and offices.

Some of their alleged victims were haunted by the wild diagnoses. One was Craig Keoshian, a Woodland Hills, Calif., chiropractor. An active athlete, Keoshian was astounded when he learned months after his tests that a life-insurance application had been rejected. "All of a sudden, this glaring thing comes up on my record stating that I have all these diseases, including

heart defects and obstructive pulmonary emphysema," says Keoshian. "According to their diagnoses, I was ready to die." It took him two years to clear his medical record.

Most of the defendants will be tried in May in U.S. District Court in Los Angeles. They are charged with 175 counts of mail fraud, money laundering, racketeering and other offenses. Michael Smushkevich, the alleged ringleader, has pleaded not guilty. His lawyer, James Barber, says the issues really should be handled in civil court, and focus on who determines what tests were "medically necessary." David Smushkevich is in Amsterdam, fighting extradition. His attorney, Howard Schecter, says David is "absolutely" not guilty.

EQUIPMENT SALES

Some of the slickest operators in the health-care field have set up what HHS Secretary Louis Sullivan calls a "high-tech, modern medicine show" that is treating Medicare like an open checkbook. Experts estimate that crooked marketers of items like seat lift chairs, oxygen concentrators, braces and home dialysis systems may be ripping the government off for as much as $ 200 million yearly by selling overpriced and unneeded wares to the elderly.

An ongoing case against a Philadelphia supplier illustrates how authorities claim the operations work. In their civil suit, federal officials allege that Mark Mickman, the former owner of a television rental business, and his companies, Federal Home Care and Home Health Care Products, filed at least 2,200 fraudulent claims and bilked Medicare out of several million dollars in 1988 and 1989. The case will not go to trial until the spring, but the government did get an injunction in December 1989, at which time a federal judge's opinion called Mickman's operation an "out-and-out scam."

Mickman's plan relied on a telemarketing operation employing teenage girls operating out of boiler rooms in Philadelphia-area shopping centers. The girls called local Medicare beneficiaries who had responded to newspaper advertisements offering a "free Medicare covered package." The telemarketers would obtain the seniors' Medicare numbers and ask them if they had any physical complaints. If so, the caller said, their firm could get equipment that would help. Though Medicare requires beneficiaries to pay 20 percent of the cost of any supplies, the seniors were told that Medicare would pay "100 percent for everything," according to the complaint. "Teenagers who had no medical training were making medical diagnoses upon which sophisticated, expensive equipment was being purchased for patients that neither needed nor wanted the equipment," said Judge Donald VanArtsdalen in a bench opinion.

Authorities say the companies easily short-circuited another "safeguard" in the system by filling out elaborate forms that only required a doctor's signature before the claim was filed. Medicare will not pay for such equipment unless the patient's doctor certifies it is necessary. Surprisingly, many doctors do sign precompleted forms. Why? Sometimes because they are buried under exasperating paperwork and don't really examine the form; sometimes because they figure the patient wouldn't have ordered it if it weren't needed, and sometimes because patients apply pressure, threatening to find another doctor if they don't sign.

When the forms were completed, Federal Home Care or Home Health Care would bill Medicare and ship the equipment, says the government complaint. Seniors attempting to return the equipment -- there were at least 50 such calls to the companies a day -- would be put on hold, cut off or told the responsible person was not available.

John McCarthy was among those ensnared in the alleged scheme. When the company called in June 1989, McCarthy was 72 and suffering from the early stages of Parkinson's disease, but he was still bowling and jogging regularly. "My wife answered the call. They gave their name as Federal something. It was our impression the government was calling," recalls McCarthy. Authorities charge that the certificate of medical necessity prepared by Federal said McCarthy was confined to his room on a floor without bathroom facilities, neither of which was true. A few weeks later, two large boxes were delivered, containing among other items a wheelchair, a commode chair and an electric heating pad. Medicare was billed $ 1,800 for the equipment. "I didn't need anything that was in the box," says McCarthy. Mickman's attorney, Neil Jokelson, said the decision to order the equipment was based on doctor-approved orders. With doctors' signatures in place, Mickman was entitled to fill the orders and bill Medicare, he says.

In many frauds, the equipment is not only nonessential but also often outrageously overpriced because suppliers have cleverly manipulateda variety of loosely drawn Medicare rules. For instance, a bed-size hunk of flimsy pink foam that cost a supplier $ 28 was charged to Medicare as a "dry flotation mattress" to prevent bedsores. Medicare was billed $ 900. One high-profit item is called a transcutaneous electronic nerve stimulator, or TENS unit, which generates electrical impulses that can help control pain. It has legitimate therapeutic benefit for some, but has been marketed as a virtual magic elixir by high-pressure pitchmen. The components could be purchased at Radio Shack for about $ 50, but Medicare is often billed $ 500 for each one.

Savvy equipment companies also take advantage of regional variations in payment rates. Medicare contracts with 35 private firms to oversee payments for equipment. Each of these "carriers" until recently had the unrestricted right to establish its own pricing schemes for the suppliers in its region. For instance, Medicare pays $ 41.93 for a wheelchair seat cushion in Tennessee, but pays $ 248.96 in Pennsylvania for the very same item. Not surprisingly, lots of suppliers have set up "branch offices" that are little more than mail drops in high-priced states.

Most shocking of all is that Medicare doesn't even know who the suppliers are, or if they are legitimate. Suppliers must be assigned a "provider number" by Medicare to get paid, but getting a number requires virtually no documentation. "It's like the government issuing a lifetime gold card with an unlimited balance and no annual service fee to these suppliers without first running a credit check," argues Sen. William Cohen of Maine.

INFLATED HOME-CARE BILLS

Like all thieves, health-care crooks follow the money, and these days, the money is increasingly in private homes. Patient preferences, new technologies and a Medicare-mandated trend toward shorter hospital stays have created a

booming $ 15 billion market in home-health-care services. More than 12,500 firms now provide some kind of home-care services, and the business is "attracting the sharks," says Kuriansky, the New York special prosecutor -- in part because the market is relatively unregulated. "From an investigative standpoint," says Kuriansky, "it's far harder to get at, because you're talking about finding out what's going on behind closed doors in hundreds of thousands of individual homes, where there may be no other witness than an incompetent, vulnerable elderly person."

In August 1990 Kuriansky's office settled one of the largest medical-fraud cases in recent times, against Professional Care Inc. of Plainview, N.Y. Professional Care and its top two officers paid a total of $ 5.2 million in restitution, fines and interest for Medicaid overcharges. In addition, PCI pleaded guilty to grand larceny and falsifying business records, while the two officers pleaded guilty to conspiracy. Working with an inside informant, Kuriansky charged that the company systematically overbilled the state over a four-year period for home health services rendered by untrained and unqualified workers, or in some cases, by no one at all. The state charged that home health aides billed for many more hours of care than they actually provided.

Right now, regulators are especially worried about the growing number of companies providing intravenous drugs or nutrients at home. These so-called home infusion services have proved especially popular for AIDS treatment. But a report by the New York City Department of Consumer Affairs charged that the home infusion market for AIDS patients was plagued by widespread price gouging. For instance, a nutritional supplement called TPN that is often used by AIDS patients wholesales for about $ 1,300 a month -- but home infusion billings for TPN ran as high as $ 10,000 monthly.

MENTAL HEALTH

Similar storm clouds are appearing over the once growing field of mental-health services. Coverage for mental-health and substance-abuse maladies sprouted in the 1970s, and the tendency among insurance firms was to reimburse for inpatient stays rather than outpatient treatment. One result was massive growth throughout the 1980s in for-profit psychiatric hospitals hoping to take advantage of these new streams of revenue. But problems began when the industry was overbuilt and insurance firms, alarmed byexploding costs, began scrutinizing payments more carefully -- a process that ultimately trimmed the average patient's length of stay.

The result is that "private hospitals that once made a great deal of money are now desperate for patients," says Dr. Alan Stone, former president of the American Psychiatric Association. And that desperation has opened the door for fraud. Among the alleged abuses: Patients abducted by "bounty hunters"; others hospitalized against their will until their insurance runs out; diagnoses and treatments tailored to maximize insurance reimbursement; kickbacks for recruiting patients; unnecessary treatments; gross overbilling.

The most infamous charges have been leveled in Texas. Last April, two security agents showed up at the Harrell family home in Live Oak to pick up Jeremy Harrell, 14, and admit him on suspicion of drug abuse to Colonial Hills Hospital, a private psychiatric facility in San Antonio that was owned by the

Psychiatric Institutes of America. Family members believed the agents to be law-enforcement officers. If Jeremy didn't cooperate, the agents said, they could obtain a warrant and have him detained for 28 days. "They acted just like the Gestapo," the boy's grandmother -- and legal guardian -- later told a Texas State Senate committee.

According to that testimony, Jeremy was denied any contact with his family for six days and released only after a state senator intervened. State officials discovered that the boy had been ordered detained by a staff doctor after his disturbed younger brother lied about Jeremy's drug use. The guards who brought him in worked for a private firm paid by Colonial Hills for each patient delivered. And the doctor who signed the admission order had falsified his own credentials.

Jo Ann De Hoyos, an attorney representing the Harrell family, claims the boy was snatched because his family was fully covered for extensive mental-health benefits under CHAMPUS, a military insurance plan. Soon after the ordeal, the Harrells got a bill for Jeremy's six-day stay: a stunning $ 11,000. CHAMPUS paid the tab but has asked the Department of Defense to investigate.

It was the Harrell case that led to those Texas Senate hearings, which in turn brought to light other allegations of fraud and abuse. They involved some of PIA's 12 other Texas facilities andat least three other national hospital chains. Similar charges have been made against hospitals in New Jersey, Florida, Alabama and Louisiana; three federal agencies have opened investigations, and more than a dozen states now have probes underway. Some have already taken legal action: The Texas attorney general is suing PIA for an allegedly illegal patient-referral system. Texas officials also suspect some psychiatric hospitals are recruiting crime victims for unnecessary treatment and billing the state's Crime Victims Compensation Fund up to $ 25,000 per patient; as a precaution, the state recently froze all reimbursements to such facilities. And last summer, a PIA-affiliated hospital in New Jersey paid the state a $ 400,000 settlement -- though it admitted no criminal wrongdoing -- after officials there alleged fraudulent billings.

Other patients who voluntarily sought help claim they were imprisoned. Among them is Susan Alderson, who told the Senate committee how her doctor referred her to Brookhaven Psychiatric Pavilion near Dallas, another PIA hospital, after she had a psychotic reaction to pain medication. "I thought I'd be there a day or two and released," she said, "but that day or two lasted three months." After learning the terms of her insurance policy with Aetna Life and Casualty, she testified, the hospital tried twice to change her status from "psychiatric" to "medical," thereby increasing her coverage from $ 50,000 to $ 1 million. She says she was heavily sedated, isolated from visitors and warned by her doctor that she'd "be in a mental hospital the rest of her life" if she made waves. When her coverage was exhausted, and a family member threatened to call the police, Alderson was told to pack her bags and leave, she claims. Once home, she learned her insurance company had paid a $ 48,864 bill.

In recent months, a number of doctors have gone public with stories portraying their former employers as greedy, unethical and corrupt. Quentin Dinardo, director of clinical services at Laurelwood Hospital in suburban Houston before he quit in disgust, says "every decision was based on dollars and cents. If you're selling shoes that might not be so bad, but we are talking about human beings." A clinical psychologist with 20 years' experience,

Dinardo claims the entire hospital staff spent half its time promoting the PIA-run facility to prospective clients. He also alleges that Laurelwood charged unconscionable fees for deplorable care.

David Olson, a spokesman for National Medical Enterprises Inc., which absorbed PIA last December, calls Dinardo's charges "absurd." Hospital employees are never required to spend half their time marketing, he says, although the company does expect staff to educate the public about services offered. "We don't regard that as unreasonable," he adds. Olson says Laurelwood offers "quality" care.

Dr. Duard Bok, who ran a chemical-dependency unit at the Psychiatric Institute of Fort Worth, makes similar charges about abuse in a recent lawsuit against that facility. The suit alleges that the PIA hospital routinely gave financial support to doctors, social workers and even local high-school guidance counselors for referring patients, and pressured doctors to change discharge orders "so patients could be maintained in the hospital for a longer period for no therapeutic reason whatsoever." Bok was fired last August, he says, after criticizing the facility's practices. PIA contends Bok was disabled by a personality disorder and that they suspended his contract only after he failed to show up for work for two months. The company has filed a countersuit.

Privacy rules prohibit hospital staff from discussing patients' cases -- like Susan Alderson's -- without their permission. But Olson disputes the general charges leveled against PIA facilities, calling allegations of abduction "absolutely, utterly false." There is no evidence to support charges that professionals are paid kickbacks to refer patients to PIA hospitals, or to detain them once they've been admitted, he says. Olson maintains the staff would never revise a diagnosis to maximize insurance coverage, though he adds that "it's not unusual for a patient's diagnosis to change" during a stay. "We're not perfect," Olson says, "but to draw the conclusion that isolated patient complaints mean widespread problems is extremely dangerous to people who need care."

ENFORCEMENT PROBLEMS

Despite the sums at stake, there has been no great call to arms against health-care fraud among government regulators, law-enforcement agencies and private insurers. There has been a recent awakening in some quarters, but the effort still too often falls victim to funding crunches and conflicting priorities.

Since 1985, 27 insurance companies have joined a special investigative consortium against fraud, and the number of special antifraud units at Blue Cross and Blue Shield plans has grown from 28 to 41 in the past three years. Several firms have developed sophisticated artificial-intelligence programs to massage computerized claims data and spot suspicious anomalies.

Still, many believe that private insurers have been sluggish in confronting fraud. A survey two years ago by the Health Insurance Association of America found that only half the companies queried had organized antifraud programs. "Health-insurance companies, with some exceptions, are content to pass the cost associated with fraud along to their customers in the form of higher

Dinardo claims the entire hospital staff spent half its time promoting the PIA-run facility to prospective clients. He also alleges that Laurelwood charged unconscionable fees for deplorable care.

David Olson, a spokesman for National Medical Enterprises Inc., which absorbed PIA last December, calls Dinardo's charges "absurd." Hospital employees are never required to spend half their time marketing, he says, although the company does expect staff to educate the public about services offered. "We don't regard that as unreasonable," he adds. Olson says Laurelwood offers "quality" care.

Dr. Duard Bok, who ran a chemical-dependency unit at the Psychiatric Institute of Fort Worth, makes similar charges about abuse in a recent lawsuit against that facility. The suit alleges that the PIA hospital routinely gave financial support to doctors, social workers and even local high-school guidance counselors for referring patients, and pressured doctors to change discharge orders "so patients could be maintained in the hospital for a longer period for no therapeutic reason whatsoever." Bok was fired last August, he says, after criticizing the facility's practices. PIA contends Bok was disabled by a personality disorder and that they suspended his contract only after he failed to show up for work for two months. The company has filed a countersuit.

Privacy rules prohibit hospital staff from discussing patients' cases -- like Susan Alderson's -- without their permission. But Olson disputes the general charges leveled against PIA facilities, calling allegations of abduction "absolutely, utterly false." There is no evidence to support charges that professionals are paid kickbacks to refer patients to PIA hospitals, or to detain them once they've been admitted, he says. Olson maintains the staff would never revise a diagnosis to maximize insurance coverage, though he adds that "it's not unusual for a patient's diagnosis to change" during a stay. "We're not perfect," Olson says, "but to draw the conclusion that isolated patient complaints mean widespread problems is extremely dangerous to people who need care."

ENFORCEMENT PROBLEMS

Despite the sums at stake, there has been no great call to arms against health-care fraud among government regulators, law-enforcement agencies and private insurers. There has been a recent awakening in some quarters, but the effort still too often falls victim to funding crunches and conflicting priorities.

Since 1985, 27 insurance companies have joined a special investigative consortium against fraud, and the number of special antifraud units at Blue Cross and Blue Shield plans has grown from 28 to 41 in the past three years. Several firms have developed sophisticated artificial-intelligence programs to massage computerized claims data and spot suspicious anomalies.

Still, many believe that private insurers have been sluggish in confronting fraud. A survey two years ago by the Health Insurance Association of America found that only half the companies queried had organized antifraud programs. "Health-insurance companies, with some exceptions, are content to pass the cost associated with fraud along to their customers in the form of higher

premiums," charges Louis Parisi, director of the New Jersey insurance department's fraud division.

The government record is spotty as well. Much of the flak is directed at the Health Care Financing Administration, which runs the $ 115 billion Medicare program and oversees the 58 private firms that process and pay Medicare claims. Congress and the HHS inspector general's office complain bitterly that HCFA is lousy at closing loopholes that invite fraud and at correcting administrative laxity. Reports with recommendations on how to fix the flaws "seem to disappear into a black hole," says Harvey Yampolsky, former chief counsel to the HHS inspector general. One such report, written in March 1988, spotlighted abuses of provider numbers by equipment suppliers, but HCFA didn't announce changes in the system until last fall. Critics are also exasperated by HCFA's delays in implementing new laws to fix the system. A 1987 law authorized HCFA to develop rules for physician investments in medical facilities, but those prescriptions didn't come out until last July.

Worst of all, HCFA is providing the private contractors with less money to watch out for fraud. Funding for these watchdog activities -- known as "payment safeguards" -- has fallen from $ 358 million in 1989 to $ 333 million in 1992, despite the fact that each dollar spent this way saves Medicare as much as $ 11.

The congressional General Accounting Office also roasted one of the contractors' primary tools for sniffing out fraud: toll-free hot lines for Medicare beneficiaries. The GAO study said that over half the calls from beneficiaries complaining of possible fraud were not properly referred for investigation. Part of the problem, says the GAO, is inadequate oversight from HCFA. Many beneficiaries complain of poor treatment when they do call. "Why do they give you this runaround?" argued Otto Twitchell, who tried to report an excessive bill. "I was beginning to feel like I was the guilty party." HCFA Administrator Gail Wilensky counters that her agency is caught in a philosophical and financial squeeze. It is often difficult, she says, to balance the conflicting priorities of getting the money out quickly, reducing the hassles for legitimate physicians and suppliers and keeping an eye out for fraud. In addition, she says, new laws require extensive time for public comments before rules can be implemented. And workload increases have outpaced manpower. Medicare claims rose from 217 million in 1981 to 600 million in 1991, but HCFA's staff has fallen to 4,027 from 4,972 a decade ago. Meanwhile, HCFA has also been overwhelmed by other duties, like instituting a massive change in physician payment rates. Wilensky notes that HCFA did announce a major package of reforms last November to clean up the medical-equipment industry. HCFA would love to hike spending to sniff out fraud, Wilensky says, but is doing the best it can under budget constraints.

The same goes for the HHS inspector general's office, which shares responsibility with the Justice Department for investigation of health-care-fraud cases. The IG's office has boosted prosecutions for 11 years, but has only 270 investigators nationwide who are also responsible for HHS's 300-odd other programs. "A lot of cases can't be opened because we just don't have the resources," says James Cottos, the IG's head sleuth in Atlanta. Cottos has just 13 investigators for the whole state of Florida, which is home to 2.3 million Medicare beneficiaries. Their overtime pay was cut off last fall.

Until recently, there wasn't much good news at the Justice Department either. The focus at the FBI and among U.S. attorneys during the 1980s was on

violent crime, the drug crisis and the savings and loan scandal. Health-care cases were boring and difficult to prove.

Those problems still exist. But a sense of alarm is slowly starting to yield more resources for battling health-care fraud. The FBI has tripled its commitment over the past three years, to 95 agents, and early this month Attorney General William Barr announced that 50 more agents would be transferred from counterintelligence duties to health-fraud probes. The number of states with special Medicaid fraud control units has grown from 31 in 1984 to 42 today.

Still, no one believes the good guys are catching more than a small fraction of the health-related crime. Many feel the system is too big and too geared toward processing the claims. Cracking down may ultimately depend on smarter, more vigilant consumers who are fed up. After all, it's their money.

TELEMARKETING

Fraud artists sell services like unneeded lab tests or unnecessary medical supplies through high-pressure phone sales operations run out of "boiler rooms." The pitch is aimed at getting unsuspecting patients, especially the elderly, to agree to undergo tests or buy high-profit medical equipment. Often, the pitch deliberately confuses people into believing the caller represents the government. Insurers or the government picks up the tab.

COPAYMENT WAIVER

Unsuspecting patients often agree to undergo tests or buy medical equipment on the promise that they will not have to pay anything for the service. Under most insurance or government regulations, the patient would have to pay a portion of the cost, usually 20 percent. But in this fraud, the provider offers to waive that copayment. The consumer sees the service as free and loses any incentive to keep an eye on what's being done.

DOCTOR SIGN-OFF

Under federal guidelines, Medicare will pay for equipment only after a physician signs forms certifying that it's needed. Rip-off artists sometimes fake these signatures or pay off corrupt doctors to sign the forms indiscriminately. Honest but busy doctors occasionally sign without thoroughly examining the forms, or sign under pressure from patients.

KICKBACKS

Health care provides many opportunities for kickbacks for steering business to suppliers, pharmacies or laboratories. A medical-equipment supplier might pay off a hospital to get a monopoly on its business, or slip cash to a doctor in return for patient referrals; a pharmacy may pay "incentives" for a nursing home to steer patients its way; labs may reward doctors for a stream of patient referrals.

HOME-CARE RIPOFF

Fraud in this booming field is hard to detect. It involves charging insurers for more services than patients got, billing for more hours of care than were provided, falsifying records and charging higher nurses' rates for care given

by aides.

PSYCH SCAM

Some for-profit mental-health facilities reportedly pay "bounty hunters" to bring in patients, hospitalize patients against their will, tailor treatments to maximize insurance payments, take kickbacks for recruiting patients and overbill for services.

Torso support

Wholesale cost: $ 7

What Medicare paid: $ 96

Wheelchair cushion

Wholesale cost: $ 8

What Medicare paid: $ 248.96

Decubitous pad

Wholesale cost: $ 40

What Medicare paid: $ 434.95

TENS

Wholesale cost: $ 50

What Medicare paid: $ 400

Wax bath

Wholesale cost: $ 95

What Medicare paid: $ 648.30

GRAPHIC: Drawings: No caption (Illustrations by Scott Swales for USN&WR); Pictures: Torso support; Wheelchair cushion; Decubitus pad; TENS (pain reliever); Wax bath (Product photos by Jeffrey MacMillan-USN&WR)

LANGUAGE: ENGLISH

2ND STORY of Level 1 printed in FULL format.

Medical Economics

August 7, 1995

SECTION: Vol. 72 ; No. 15 ; Pg. 172; ISSN: 0025-7206

LENGTH: 5211 words

HEADLINE: When a doctor accuses colleagues of health fraud; internist J. Hilton Brooks

BYLINE: Rice, Berkeley

BODY:

This internist reported conduct that may have cost taxpayers millions. His life has been in turmoil ever since.

Internist J. Hilton Brooks wasn't looking for trouble when he arrived in Pineville, Ky., in the fall of 1986. Fresh out of residency and board-certified, he could have set up shop in much larger Middlesboro, his nearby hometown. But he saw a greater need for his services in rural Pineville (population less than 3,000) where he took over the practice of a retiring physician.

The 100-bed Pineville Community Hospital, whose assistant administrator was his cousin, provided Brooks with free office space for the first year. By 1988, the internist was serving on several hospital committees, including quality assurance and medical death review. He was also elected to the hospital's board of directors, an honor for a newcomer - and one most board members came to regret when he later sued the hospital and his colleagues for Medicare and Medicaid fraud. (The following account of what took place is based on depositions, affidavits, other court documents, and interviews with some of the individuals involved.)

Through his committee assignments at Pineville, which involved reviewing patient charts, Brooks discovered that several of his colleagues weren't actually performing some of the physicals and other services listed in those records.

In a typical such case, a Medicare patient would arrive in the ER and receive a physical exam and initial treatment. If she required hospitalization, the ER doctor would call and discuss the case with the attending physician, who would admit her and give orders for her treatment. Later that day, or possibly the next, a medical records clerk would write a history based on the patient's prior admissions and, if necessary, on an interview with the patient.

The clerk would also fill out a physical-exam report, using the vital signs and other findings from the ER physical and stock phrases from the attending's standard form, known as a "normal." The clerk would then stamp the H&P report with the attending's signature over his typed name and that of the ER doctor. That document, created by the records clerk with no direct patient contact by the attending, became the basis for his bill to Medicare for a comprehensive history and physical.

Over the following days, the attending physician might stop by and examine the patient during morning rounds. Or he might not, if he felt there was no pressing need, or if he happened to be busy in surgery. In that case, his office nurse would check on the patient, write progress notes or orders in the chart, and sign the doctor's initials followed by her own. His office would bill Medicare for an intermediate hospital visit by the doctor.

At the end of the patient's stay, the medical records clerk, using information from the chart, would fill out a discharge summary and stamp it with the doctor's signature. The doctor's office would bill Medicare for a discharge exam and treatment plan. After each discharge, the records clerks would review the chart and "authenticate" any unsigned entries with the doctor's signature stamp.

For some Pineville physicians, these were occasional practices. For others, they were routine. When Brooks protested that they were wrong, the hospital's administrator and chief of staff told him they were simply a service the hospital had always provided to help its busy doctors. To Brooks, such "assistance" was unprofessional, unethical, and unsafe (see page 184).

* A zealous reformer runs into stubborn resistance

When Brooks complained about these practices at medical staff meetings, his colleagues' reactions ranged from exasperation to hostility. They advised him to go along with "the way we've always done things here." Hospital-board members responded similarly; one warned him, "Don't try to change the system."

In fact, Brooks had stumbled into a thicket of professional and personal relationships. The four doctors on Pineville's medical staff executive committee, including the chief of staff, all engaged in some of the practices to which Brooks objected. But they also produced the great majority of the hospital's admissions. All of them had served on the hospital's board of directors. Three were partners in - and practiced at - Total Care, the town's big private clinic. The chief of staff's office nurse was the wife of a hospital-board member. Another committee member's nurse served as the hospital's director of quality assurance.

Much of Brooks' committee work led him to criticize his colleagues' conduct or treatment, which did little for his popularity. When he tried to review the chart of one patient who he suspected had received improper medication, the attending doctor took the chart and refused to turn it over. Brooks reported the incident to hospital authorities.

When Brooks persisted in his complaints, his colleagues began to boycott him. Several refused to consult or share call with him or to let him interpret their Holter-monitor tracings. To document what he considered a conspiracy against him, Brooks once brought a minirecorder to a staff meeting and secretly taped the following exchange with GP Emanuel Rader over allowing medical records clerks to fill in patient histories based on their prior admissions:

Brooks: "And why are they doing that when the physician should be doing that already?"

Rader: "They're helping us out, Hilton ... they've done it for 30 years, and I want them to keep on doing it for me."

When Brooks complained about the fabricated charts and other violations to his cousin Milton Brooks - who had become administrator by then - Milton refused to intercede. As Hilton Brooks recalls, his cousin replied, "You just can't change things around here that quickly," and suggested that Hilton "back off."

During a hospital construction project in the summer of 1988, Brooks worried that patients were being exposed to asbestos. Milton assured him the material wasn't asbestos. So Brooks sent a sample to a lab, which found that it was. When he relayed this information to Milton, he recalls, his cousin told him to mind his own business. The doctor felt patient safety was his business. He reported the incident to the state environmental agency, which investigated and fined the hospital. After that, Hilton Brooks says, his cousin stopped talking to him.

* Reprimanded by the state board and hospital, Brooks sues

Brooks had a particularly difficult relationship with OBG specialist Lawrence Butcher, whom he'd criticized on several occasions. In July 1988, as Brooks was preparing for an endoscopy in the OR, Butcher stormed in and began yelling and cursing at him in front of several OR staffers. As Brooks recalled in his deposition, "He said that if I didn't shut my mouth he was going to knock my teeth out." While this altercation took place, Brooks' patient was listening from one OR suite while Butcher's patient was being put under anesthesia in another.

Brooks reported this incident to the Kentucky Board of Medical Licensure. The KBML investigated and wrote to Brooks, Butcher, and the hospital, admonishing the two doctors for their "unprofessional" conduct. Relying on the KBML's letter, and without conducting an investigation or hearing, the hospital's executive committee issued its own reprimands to the two doctors. Outraged, Brooks demanded retractions from the board and the hospital. When they refused, Brooks sued the KBML. (Last summer, after a lengthy legal battle that ended in a state court ruling in his favor, he succeeded in having both letters rescinded.)

By then, Brooks' complaints had become a regular feature of medical staff meetings, often accompanied by his implied threats of legal or regulatory action if things didn't improve. Brooks insisted he was simply trying to assure that Pineville's patients received proper care. But the physicians whose conduct he questioned came to think of him as a meddler who insisted on having things done his way or not at all. In interviews, they described him as a "nitpicker," "a loose cannon," and "a pain in the ass."

* Brooks takes his complaints to higher authorities

By 1989, Brooks realized that his complaints had produced nothing but indifference and opposition. He therefore resigned from his committees and the board of directors. If hospital officials took that as a sign of defeat, however, they grossly underestimated him.

Over the next year or so, Brooks sent or brought his complaints to officials at Medicare, Medicaid, Blue Cross and Blue Shield, the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, Kentucky's agency for hospital licensing and regulation, the U.S. Attorney's office in Lexington, and to his congressman.

His appeals had little effect, however. Some of the agencies apparently never investigated his charges. Those that did substantiated some of them, but showed little enthusiasm for enforcement. One official, after reviewing Brooks' charges, suggested that he leave town.

The internist's efforts did prompt an investigation by Medicare, which found numerous examples of "upcoding," "undocumented services," and "possibly fraudulent" billing. The Medicare audit described a particularly high rate of "discrepancies" in the records of general surgeon and Chief of Staff Jerry Woolum. Out of 27 intermediate-level services billed by Woolum, only about half were sufficiently documented to support the level of care or, in several cases, even to verify his presence, the auditors said.

Despite such evidence, none of the agencies pursued the possibility of fraud. Some officials expressed "concern" about the abuses they found at Pineville and recommended procedural changes. Most simply accepted the hospital's assurances that changes had been or would be made. (The medical records staffers did stop using the doctors' signature stamps.)

In a typical response, the medical director of the state's Medicare peer review organization cited "the poor quality" of Pineville's histories and physicals, which he described as "exact duplicates" of the ER physician's exam. He suggested that "this problem could be remedied if there were involvement of the attending physician in these important aspects of patient care." He promised his agency would "continue to monitor" the situation.

* His privileges threatened, Brooks sues the hospital

Annoyed by all this attention, hospital officials chastised Brooks for "going outside" with his complaints instead of trying to "work within the system." By then, however, they realized he wasn't going to give up his crusade, and they decided he had to go.

In December 1989, Brooks received an official letter from hospital administrator Milton Brooks informing him that the executive committee had recommended against his reappointment to the medical staff. Among their reasons: his "hostile, and antagonistic, and disruptive" attitude and conduct toward members of the medical staff, and his "continued threats of litigation and investigation," which had "created an atmosphere of fear and intimidation."

"None of this had to happen," Milton Brooks recently told Medical Economics. "We could have dealt with it without all this trouble if Hilton hadn't gone and filed all those complaints. Now, I'm not saying there weren't some things that needed to be changed here. But he comes in and from the very beginning starts telling us things have got to change, and right away. That's just not the way you do things around here."

Calling the committee's decision "arbitrary and capricious," Hilton Brooks demanded a hearing on his threatened termination. But negotiations over the composition of the hearing panel degenerated into another protracted dispute and, eventually, another suit from Brooks, which was dismissed on jurisdictional grounds.

By then, it was clear to the doctor that his days at the Pineville hospital were numbered. One indication was a black rose delivered to his office, with a

card that read: "From the employees of Pineville Hospital." He had already moved to Middlesboro (where he had courtesy privileges at the hospital), and in 1990 he established a part-time practice there.

* Brooks turns his complaints into a federal case

While Brooks continued to press state and federal agencies, their lack of action led him to explore other legal options. In 1991, he learned about the federal False Claims Act, which allows private citizens to file suits on behalf of the federal government if they have evidence that the government was defrauded (see page 190). Since the government had paid all those questionable Medicare and Medicaid claims, he felt he had sufficient grounds.

Brooks contacted William Copeland, a health lawyer in Cincinnati. Copeland agreed to take the case and brought in as co-counsels William Markovits, a former Justice Department prosecutor, and Thomas Miller and Judith Jones, both lawyers in Lexington. In December 1992, they filed a false-claims suit against Pineville Community Hospital and general surgeons Jerry Woolum and Talmadge Hays. The U.S. Department of Justice declined to join the case, but reserved the right to intervene later.

Brooks and his lawyers targeted Woolum and Hays because those two surgeons admitted about half of Pineville's patients and filed far more Medicare and Medicaid claims than their colleagues. Both had served as the hospital's chief of staff, chairman of its medical executive committee, and member of its board of directors.

Representing the two doctors, Lexington attorney Robert Houlihan Jr. admitted that their billing practices might have been "inappropriate." But in a recent interview with Medical Economics, he denied that they had done anything illegal or had intended to defraud the government.

"This is not a fraud case at all," Houlihan insisted. "Fraud implies an intent to deceive. They may have been sloppy and unsophisticated with their documentation and billing. But they never sat down and tried to figure out how to gyp the government." Houlihan contended that the two surgeons' billing practices were common at many hospitals. The fact that several government agencies had been aware of those practices without taking action, he argued, showed that they weren't illegal.

In their affidavits and depositions, Woolum and Hays admitted that medical records clerks had prepared "some" of their H&Ps and discharge summaries, and that their office nurses had "occasionally" checked on their patients for them when they were busy in surgery. The doctors insisted that they usually did their own physicals on the day after admission and saw their patients on subsequent days, though they didn't always document those visits in the patients' charts. They admitted having billed for those services, however, whether or not they'd actually seen the patients on those days. They felt entitled to bill for them, they explained, because they were responsible for and were supervising those patients' care. As for the allegedly false claims, they said they had relied on their office staffs to send out correct bills, which they rarely reviewed.

* Experts debate the allegations of fraud

The two doctors claimed that these practices had been routine at Pineville since they had arrived in the early 1970s. Woolum described them as "purely an effort on the part of the hospital to assist busy doctors with documentation." Defending the use of medical records clerks to create their H&Ps, Hays explained that most of their admissions were "patients whom we've come to know over the course of the past 20 years, ... and to sit down and create a voluminous history and physical ... was inappropriate as far as I was concerned, and a waste of time."

"What we did was not fraud," Hays told Medical Economics. "It was a failure to understand and comply with regulations. Sure, we took shortcuts, and I realize those methods are no longer appropriate. But we never tried to devise a scheme to defraud the government and enrich ourselves."

To support their case, the defendants produced an affidavit from Joseph Leiker, former medical director for Blue Cross and Blue Shield of Kansas, that state's Medicare carrier. Leiker stated that he had seen similar billing practices as a Medicare administrator. He called them "errors" or "mistakes," and said they "do not rise to the level that they would or should be treated as fraud by Medicare."

Brooks' lawyers produced several experts who disagreed with that opinion. In his deposition, James Holloway, Kentucky's medical director for Medicare, said he had never before encountered a case in which medical records clerks routinely prepared histories, physicals, and discharge summaries for attending physicians. Asked whether the Pineville doctors might have been unaware of what was going on, Holloway replied, "It's difficult for me to see how it could happen without being deliberate."

Cheryilynn Reagan, then manager of surveillance and utilization review for the state's Medicaid program, stated in her deposition: "In order for the Medicaid program to make payment to a physician for a service provided to the recipient, there must be actual physician-patient contact. The physician can only bill for services actually performed. If a physician didn't see the person, and didn't prepare the records, then as far as we're concerned, they didn't do the service, and they shouldn't have sent a bill in for it."

Barry Steeley, former Chief of the Health Care Branch at the HHS Office of Inspector General, refused to accept Woolum's and Hays' attempts to blame false billings on their office personnel. The Medicare billing form, he explained in his statement, "makes clear that by sending in the bill the physician is certifying that the services claimed were necessary, and were personally furnished by the physician....Given that the above practices were not an isolated mistake, but were apparently a routine practice that took place over a number of years, in my opinion the billings resulting from these practices would be treated as false claims stemming from fraud, or at the very least reckless disregard."

As for the hospital's liability, several medical records clerks said in depositions that they had provided their "documentation" services for the doctors under instructions from or with the knowledge of the hospital's senior staff and administration. Milton Brooks, Pineville's administrator, denied any knowledge of this.

According to a statement by Paul Osborne, former CEO of the Kentucky Peer Review Organization, the practices of the hospital's personnel constituted "a knowing disregard for ethical and legal requirements," as well as "conduct that is dangerous to the patients involved." Discovery of those practices, he said, "should have resulted in denial of the hospital's claims for payment, and such a pattern should have been, reported immediately to the U.S. Department of Health and Human Services for a fraud investigation." He called the case "the worst" example of fraud he had ever encountered.

But Milton Brooks defends the billing practices. "Look," he explained recently, "we're a small rural hospital with a small medical staff. All of the doctors here are so busy that we have to help them out with their records. What do you want them to do, take care of paperwork or take care of patients? That's just simple economics. And it's probably common at lots of other small rural hospitals."

* The state finally acts, and the community reacts

In October 1994, following news accounts of the allegations of fraud at Pineville, state Medicaid officials launched their own belated investigation. Masten Childers II, the state's new Secretary for Human Resources, said he wasn't surprised that Medicaid officials had taken no action despite having known about the improper billing at Pineville since 1990. "As long as the providers would say they wouldn't do it anymore," Childers told the Lexington Herald-Leader, "they wouldn't pursue it. It's just another example of the way Medicaid coddled doctors and other providers for years."

Soon afterward, Childers notified Woolum and Hays that their Medicaid privileges would be terminated. For Pineville hospital, that meant two of its three surgeons would no longer be able to treat the area's many poor patients. For Woolum and Hays, the termination represented a considerable financial blow. According to the Herald-Leader, the two doctors had received nearly $ 540,000 from Medicaid billings in 1993.

Woolum and Hays vehemently denied the charges against them. "I have never knowingly billed for a service that I did not perform," Woolum told reporters for a local television news program. "I hold the practice of medicine very sacred."

The citizens of Pineville rose to the two surgeons' defense. The Pineville Sun ran columns and letters testifying to their competence and character. There were petitions, ads, and a telephone campaign demanding their reinstatement. Hospital staffers wore blue and purple ribbons - the colors of the surgeons' charts - to show their support. The hospital hung banners urging residents to "support your local doctors." As administrator Milton Brooks explained: "We want everybody to know that we are behind them. These aren't criminals. They're good docs."

For many Pineville residents, the bad doc in this case was Hilton Brooks, who became the focus of their anger. His wife received a couple of threatening phone messages about that time. One caller said, "Tell your husband he's a dead man."

Childers and the surgeons eventually worked out a settlement under which he agreed to rescind their termination in exchange for their agreement to provide three months of free care to Medicaid patients. Their lawyer, Robert Houlihan,

claimed the agreement was an acknowledgment that his clients' mistakes were "clerical, and not criminal."

• Brooks, Woolum, Hays, and the hospital all settle

Although the false-claims suit asserted that Woolum and Hays had been filing fraudulent bills since at least 1982, it focused on the years 1987 and 1988 because those were the only ones for which Brooks had access to complete records. During those two years, the suit alleged, Woolum and Hays had admitted more than 1,000 Medicare patients through the ER and had billed the government an estimated total of $ 120,000 for fraudulent H&Ps and discharge summaries. Figuring penalties of $ 10,000 for each false claim, plus treble damages for the amount of the unsupported charges, the suit asked for total damages and penalties of $ 31 million.

Last year, as the case was heading for trial, the federal government finally stepped in. The main reasons for the government's entry: the likelihood that Brooks would actually win the case and the fear that a big award in a jury trial might bankrupt the hospital. As the area's major health-care provider and the town's largest employer, its demise - according to the hospital's attorney, Pete Cline - would have been a social and economic disaster.

Last April, under pressure from the state and federal governments, a settlement was reached that left each party at least partially satisfied. Under the terms of the settlement, Pineville Hospital agreed to pay the government $ 2.3 million, and Woolum and Hays agreed to pay $ 100,000 each.

Out of that $ 2.5 million, $ 675,000 came off the top for Brooks' lawyers' services; the doctor got another $ 65,000 for his own legal costs outside of attorneys' fees. He'll also keep one-fourth of the remainder, or $ 440,000, out of which his lawyers will receive one-third as their contingency fee for winning the case. The government will keep about $ 1.3 million.

In a separate settlement, the hospital agreed to pay Brooks an additional $ 300,000 to settle any potential claims for the hospital's alleged retaliation against him. It also granted him courtesy privileges, which he insisted on "as a matter of principle," even though he had stopped practicing there after filing the suit.

Although Woolum and Hays admitted in the settlement that they'd violated regulations governing Medicare payments, they didn't concede having done so knowingly. That would have constituted fraud - and grounds for exclusion from Medicare and Medicaid.

Pete Cline, the hospital's attorney, explained that the hospital had paid most of the settlement because otherwise the surgeons' practices might have been destroyed. When the hospital paid another $ 300,000 to settle the state's Medicaid claim, the state agreed to drop its demand that Woolum and Hays provide free care to their Medicaid patients. The hospital board, of which both doctors were current or past members, also agreed to pay the doctors' legal fees.

One final condition of the settlement: The hospital agreed to conduct - and pay for - a training program in Medicare and Medicaid billing procedures and regulations, to be attended by all administrators, directors, medical records staff, physicians, and their billing clerks.

• Brooks is still paying the wages of obsession

In Pineville today, there's still plenty of support for Woolum and Hays, and plenty of animosity toward Brooks. Many folks there see the settlement as a miscarriage of justice and figure Brooks "did it for the money." As one Pineville doctor told the Herald-Leader, "All that money he's going to get for this, he better take it someplace else, because I really think somebody here will kill him."

If Brooks really "did it for the money," his suit was a failure. After his lawyers' contingency fee is deducted, his share of the recovery comes to less than $ 300,000, plus the $ 300,000 he received from the hospital. But he figures the case cost him nearly that much in lost practice revenue over six years. He also spent $ 30,000 on legal costs in his other suits against the hospital and the state medical board.

"I'm fortunate that I come from a fairly well-off family," Brooks says. "I had no medical-school debt, and no mortgage, and I did have some savings. Otherwise, I couldn't have sustained myself through this case."

The suit also represented a considerable financial risk for Brooks. If he had lost, the defendants could have countersued for defamation and for their legal expenses.

In addition to money, the case took up a great deal of Brooks' time and energy. For several years, he devoted nearly every evening and weekend to it, and lots of his days. He did much of his own legal research, sending a steady stream of letters and faxes to state and federal officials and his lawyers. The resulting documents and correspondence now fill a dozen file drawers in his office.

Brooks readily admits to being obsessed by his Pineville battles. "I have deep-seated convictions about what's right and wrong," he explains, "and what they were doing was definitely wrong. I was sure that once I brought these things to their attention, they'd stop doing them. And I would have been satisfied if they had. But they didn't. I wouldn't have filed the suit if I had thought those were innocent mistakes."

RELATED ARTICLE: Diagnosis: "Gastroenteritis" Outcome: Death

On Saturday, Jan. 2, 1988, an elderly widow named Juda Keyes was brought to the ER at Pineville Ky. Community Hospital complaining of diarrhea, vomiting, abdominal cramps, and pain. After a physical exam and X-ray, the ER physician called general surgeon Jerry Woolum, who agreed to admit Keyes (whom he'd never seen before) as attending physician.

According to Keyes' hospital chart, and to the $ 100 claim Woolum later submitted to Medicare, the surgeon conducted a comprehensive history and physical exam later that afternoon. But in fact, he hadn't actually seen her that day. As he explained later in a deposition, "I had made rounds that day, and saw no reason to make rounds again on her, on an elderly patient with gastroenteritis."

The "findings" recorded in Woolum's admission physical on Keyes were remarkably similar to those in the ER doctor's exam. Her temperature, pulse,

respiration, blood pressure, and other signs were exactly the same on both records. Each one described an "89-year-old white female who has been having many bouts of diarrhea and vomiting 2 days now. She is getting weak and dehydrated. She can't eat. She is complaining of abdominal soreness." Under "heart," each record read: "Regular rhythm, no murmurs." Under abdomen, each reported "no palpable mass." Both concluded with the diagnosis "Gastroenteritis with vomiting and dehydration."

Unfortunately, that wasn't Keyes' problem. As an ER X-ray revealed, the 5'6", 120-pound woman did have an abdominal mass. In fact, the radiologist's report described a "huge aneurysm of the abdominal aorta, size of a grapefruit." But the ER physician had missed it, and so, according to the record, had Woolum. His lapse was more understandable, however, since he hadn't seen the patient yet. By the time he did, he was too late to help.

After repeatedly complaining of abdominal pain, Keyes went into respiratory arrest the next morning. She was intubated and transferred to the ICU, where Woolum was called in to examine her. She died about an hour later. On her death certificate, Woolum listed "acute myocardial infarction" as the cause. But she hadn't complained of chest pain or had an ECG on admission. As Woolum himself later conceded, and as a report on a second X-ray (done just before she died) suggested, the actual cause of death might "possibly" have been a ruptured aortic aneurysm.

RELATED ARTICLE: The False Claims Act

The federal False Claims Act, under which internist Hilton Brooks sued Pineville Ky. Community Hospital and two of its prominent physicians, enables the government to sue suppliers of goods and services.

The law was originally passed during the Civil War to combat ripoffs by companies providing military supplies to the Union Army, such as cannon shells filled with sawdust instead of gunpowder. To encourage private citizens to blow the whistle on such practices by bringing suit on behalf of the government, the law offered them a portion of whatever sums were recovered.

In 1986, Congress amended the False Claims Act to help expose fraud by federal contractors. As amended, the law rewards whistle-blowers with up to 30 percent of any funds recovered, depending on the extent of the government's involvement in their suits. Those sums can be sizable, since the law calls for penalties of $ 5,000 to $ 10,000 for each false claim, plus damages of three times the total amount of the overpayment.

The law specifically protects plaintiffs from retaliation by their employers. But if a suit isn't successful, a plaintiff can be sued by the defendant for bringing a frivolous or malicious claim and be held liable for damages, a stiff fine, and the defendants' legal costs.

Since the law was amended, the number of private false-claims suits has grown sharply. About 220 cases were filed last year alone, of which nearly one-fourth involved health fraud. Recoveries amounted to $ 378 million, more than twice the total for 1993.

GRAPHIC: Photograph

SIC: 8011 Offices & clinics of medical doctors

IAC-NUMBER: IAC 17389235

IAC-CLASS: Trade & Industry

LANGUAGE: ENGLISH

LOAD-DATE: November 08, 1995