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The slippery slope of health industry fraud

We hear so much about what constitutes health care fraud: false billing, upcoding, unbundling, kickbacks, self-referrals, substandard care, etc.

How does fraud begin? What is its origin? Do we really have an industry of greedy professionals as the Office of the Inspector General (OIG) and the media would have us believe? Do we really have an industry comprised of dishonest human beings or of uninformed health care practitioners making choices considered

neared completion under the old Medicare cost-based reimbursement system. Everything has been going great; this nursing home even has a history of state Department of Health deficiency-free surveys for two consecutive years.

There is, however, a problem. The Balanced Budget Act of 1997 is law and this nursing home is faced with severe cutbacks based on the prospective payment system (PPS). Ill-prepared for this, the administrator begins to worry about the impact PPS — coupled with Medicaid cutbacks — will have on cash flow and continued diversification projects. The administrator, however, has difficulty explaining these concerns to the board of directors, comprised primarily of owners familiar neither with the industry nor its day-to-day operations.

As a result, there's a mismatch of expectations. The board continues to expect growth and positive cash flow. The administrator, however, sees those are not likely to continue, at least for a few years. For the first time in years, the administrator is facing the real possibility of failing to meet board expectations. To make matters worse, the directors have clearly communicated to the administrator that its expectations must be realized. Or else!

Experienced health care administrators would recognize that this nursing home must suck in its breath, tighten its belt, dig into cash reserves and expand its revenue source to include managed care payers. Experienced administrators would anticipate that Congress' initial overreaction in the Balanced Budget Act would be met a year or two down the road by a second overreaction, but in the opposite direction in the form of relief, which is exactly what has happened. But this nursing home doesn't have an experienced administrator. She's terrified she won't be able to meet her directors' expectations. In fact, the board is pressuring her even harder to grow revenues, add a new wing and increase cash flow. The administrator worries about failing.

We now have a corporate environment that includes intense pressure, aggressive growth targets and a clear message that those targets must be reached.

The administrator realizes the targets won't be reached. No way, no how. Medicare reimbursement simply won't be there, at least over the next few years. Added competition from assisted-living facilities has increased the difficulty in filling beds and admitting sicker patients who cost more to care for. Staff already has been reduced as much as possible. Group purchasing opportunities, too, have been maximized. What else can be done?



THE LAW & MORE

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fraudulent? To hear OIG speak of it, the entire health care industry is corrupt, just waiting for opportunities to rip off the system. Does OIG think health care practitioners are spending time and money with their lawyers dreaming up new ways to maneuver around fraud and abuse laws and regulations in an effort to maintain high profit margins?

I think not.

True fraud, as distinguished from accidental mistakes, starts and grows within a particular type of corporate environment — one that can be found throughout the health provider field: physician office, long-term care nursing facility, sub-acute facility, hospital, home health care agency, surgicenter, out-patient rehab facility, etc.

Let's illustrate with a long-term care nursing facility in New Jersey. This particular home has successfully and quickly grown into diversified areas, including sub-acute and outpatient rehabilitation. All this was initiated and

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The choices

The administrator has two choices: The first is notify the board that she anticipates failing to achieve its goals. This is, of course, totally unpalatable, especially after the success she's enjoyed. The other alternative is fudge the financials just a bit to make it look like — for this financial quarter only — the home will meet its goals. She chooses the latter option.

But how does she do this? She decides to meet with her rehab director to ensure the resource utilization groups (RUGs) categories are being maximized for billing purposes. After all, doesn't the nursing home have a new group of therapists? The previous therapists who had worked for a national company were not rehired when their employer was fired last year. PPS had certainly brought about a lot of changes. Perhaps these new therapists, many of whom are recent graduates, aren't really skillful enough in maximizing legitimate opportunities to bill through the RUGs program. The rehab director gets the message loud and clear: If in doubt, record the patient in the higher RUGs category. We'll work out the supporting documentation later, if necessary. This seems to work. Invoices show increased charges, and the nursing home population, when looked at from a RUGs category perspective, appears to be getting the amount of therapy it deserves. The administrator is pleased because the board is pleased.

This approach appears to work for the first quarter. In fact, what started as a strategy for one quarter has spread into the second and third quarters. The administrator found it difficult to rescind her directive to the rehab director once the increased revenues begin arriving. The administrator also thought the other strategies, including increasing revenue from managed-care payers, would have worked by now. The other strategies have not worked. Unfortunately, because of PPS — something beyond the administrator's control — cash flow continues to weaken, albeit at a slower rate had the administrator not taken her extraordinary steps. So, despite increases in RUGS categories, PPS continues to have its effect. But now, not only is there the anticipated decreased cash flow, there also is a new problem in having inappropriately increased the RUGS categories.

Problems compound

The administrator begins to worry. How likely is it that OIG will knock on the door during this, the fourth quarter? Or ever, for that matter? She did hear, however, that a nursing home in North Jersey was recently visited by OIG and the investigation wasn't pretty. Nevertheless, she decides her more immediate concern is meeting the board's expectations. But revenues continue to drop despite her best efforts and, as she now admits to herself, her unlawful strategy of increasing RUGS categories.

The administrator further becomes alarmed by her suspicion that the therapists have stopped struggling with the question of what is the proper RUGS category to use and instead are automatically upgrading them one full classification.

Now, nearly one year after the administrator began to fudge the financials just a bit, she's panicking over facing continued cash flow declines and possible patterns of intentional misrepresentations in the therapy department. To make matters worse, outside accounting auditors are due soon for the annual cost reports. Surely they'll see what's happened. She finds herself instructing the rehab director to change patients' rehab records to support the higher RUGS categories. More and more, the administrator feels as if she's on a treadmill, having to run faster and faster just to stay in place.

What started as just the administrator's efforts to maximize billing during the first quarter now includes fraudulent participation by the rehab department and unknowingly by the accounting

department. The nursing facility is ripe for a *qui tam* (whistle-blower) action to be filed or, with more immediate and severe consequences, a telephone call to be made directly by an anxious employee to OIG. Therapists misrepresenting the proper RUGS categories and the rehab director all know they're doing something wrong. They're anxious about the pressure they're under to continue their patterns of fraud and yet are even more anxious about getting caught.

What began as a way to help the administrator and the nursing home has turned into serious issues of potential civil and criminal liability. Unfortunately, these employees have now participated in what will clearly be considered fraud. They're in too far to extricate themselves.

Had a corporate compliance program been in place, one of two elements would have prevented, or at least limited, this fraudulent behavior: first, an auditing system to review and compare medical records and billing statements; second, the availability of a corporate compliance officer to whom these anxious employees could turn regarding their concerns. However, in this illustration, there is no system or officer because there is no corporate compliance plan. The board earlier declined to put such a plan in place because it believed it had an honest staff. But now, the administrator seeks an exit strategy.

The administrator calls a health care attorney who specializes in developing and implementing corporate compliance programs. She explains briefly and desperately that the nursing facility provides good care and is run by honest people, but she nevertheless recognizes the need for a corporate compliance program should OIG ever come calling. She confirms with the attorney that such a compliance program, if effective, may minimize any civil and criminal penalties should the government impose them. The attorney agrees to begin work immediately. However, before the assignment can begin, the dam breaks.

Word gets out to OIG that something's wrong and that altered documents are about to be destroyed. The administrator is faced early one morning with FBI agents brandishing guns, holding search-and-seizure warrants for all patient data. Computers are loaded into trucks. Filing cabinets are carted off. Medical records are taken away. Anything of questionable value to the investigation is taken. The nursing home is left in a complete financial and clinical shambles. The attorney hired to begin a compliance program is standing at the front door, helpless to intercede and realizing the administrator's effort to initiate a corporate compliance program was too little, too late.

Things to remember about fraud:

- It doesn't start with dishonesty.
- It starts with pressure.
- It starts one small step at a time.
- It starts with what might be considered "gray" areas.
- It increases in complexity and scope over a long period.
- It locks in its participants so there's no escape.

The solution

Fraud starts with good intentions: to continue building the organization and to continue providing jobs for employees. But the slope is slippery from there. What often begins as a one-person effort eventually involves many. A corporate compliance program, seriously initiated, implemented and maintained, is the only way to ensure that nascent fraud does not begin and spread throughout an organization. Once that happens, the only option often available for an otherwise honest organization without a corporate compliance program is to confess. The organization must seriously consider approaching OIG before it and/or the Justice Department approaches the organization.