# Health Care Fraud Investigations

## Testimony before the

## Committee on Ways and Means Subcommittee on Oversight

## By

**S. Scott Ward, CFE, AHFI**
**Senior Vice President**
**Health Integrity, LLC**

## September 28, 2016

Good morning, Chairman Roskam, Ranking Member Lewis, and members of the subcommittee. I am Scott Ward, Senior Vice President of Health Integrity, LLC and Program Director for ZPIC Zone 4. I appreciate the opportunity to tell the committee about the important work we do to support the Centers for Medicare & Medicaid Services (CMS) in protecting the integrity of the Medicare and Medicaid programs.

Health Integrity, LLC—a non-profit corporation incorporated in 2006—is a wholly-owned subsidiary of Quality Health Strategies, Inc. (QHS). Health Integrity's corporate headquarters are located in Easton, MD; we have nine branch offices in Maryland, Texas, Pennsylvania, Florida, and Georgia. With 285 nationwide employees, Health Integrity's large resource pool includes statisticians, data analysts, predictive modeling specialists, medical directors, registered nurses, certified coders, subject matter experts, communication specialists, auditors, investigators, and business analysts. Our staff understands the healthcare delivery system and the differences in provider fraud, waste and abuse actions across all provider types, all settings of care, and in the fee-for-service and managed care payment environments.

HI is a trusted, experienced and highly competent Medicare and Medicaid contractor for CMS and selected states. We understand how fraud is committed, how abusive practices lead to poor and inadequate patient care and program abuse/vulnerabilities. We also know how beneficiary and provider improper actions cause wasteful expenditures of program funds and ultimately improper payments.

Our contracts with CMS include all aspects of the Medicare program integrity operations. We are the Zone Program Integrity Contractor (ZPIC) for Zone 4 that reviews Medicare fee-for-service claims for the states of Texas, Colorado, Oklahoma, and New Mexico. In addition, we are the National Benefit Integrity Medicare Prescription Drug Contractor (NBI MEDIC) with responsibility to identify and investigate incidents of fraud, waste, and abuse in the Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) programs. We are also the Audit Medicaid Integrity Contractor (Audit MIC) that identifies Medicaid overpayments in as many as 34 states and the District of Columbia.

## *ZPIC Contractual Operations*

Health Integrity (HI) was awarded the ZPIC Zone 4 contract on September 30, 2008 as the first ZPIC awarded by CMS. The primary focus of the ZPIC is to protect the Medicare Trust Fund by preventing, detecting, and deterring fraud waste and abuse in the Medicare and Medicaid programs. The ZPIC's authority includes investigating and analyzing Medicare Parts A&B, DME, home health, hospice and the Medicare-Medicaid data match programs operated in conjunction with state Medicaid agencies. These investigative activities are conducted through proactive and reactive activities to identify program violations so that immediate actions may be taken to correct these problems and help ensure that future fraudulent billing practices or improper payments are not made.

The process in which the ZPIC obtains a lead for investigation is through multiple channels, all of which, go through the hands of multiple Health Integrity departments each with their unique functions and expertise. There are both reactive and proactive leads. Reactive leads are identified from outside source complaints (e.g. referrals from the Medicare Administrative Contractor (MAC), beneficiary complaint, ex-employees, Office of Inspector General (OIG) hotline complaints and the CMS Fraud Prevention System). The Fraud Prevention System (FPS) uses predictive models to identify suspicious providers. HI receives Alert Summary Reports (ASR) from FPS on a daily basis that identifies providers in Zone 4 for possible fraud, waste, and abuse. HI utilizes information in the ASR and conducts additional data analysis and research to determine if the ASR warrants investigation. Proactive leads are identified through data analysis, local knowledge, subject matter expertise, and policy review.

Health Integrity utilizes Intake Investigators to review the incoming proactive and reactive leads to conduct a preliminary analysis of multiple factors including: the amount of money involved in the allegations, the seriousness of allegation (i.e. is quality of care a factor), Medicaid exposure, type of allegation (e.g. medical necessity vs non-rendered services), the area in which the allegation is located, and the source itself. The results are applied to a prioritization matrix to determine the priority level of the investigation. When the lead meets criteria for investigation it is passed onto the investigative team headed by Lead Investigators who maintain quality control of work product and workload equality.

A typical preliminary investigation includes interviewing beneficiaries, site verifications of provider offices (to determine they are an active provider and ruling out False Front providers), and further background review (e.g. further data analysis which would include peer review,

procedure and utilization review, referring provider review, and cross-claim analysis between Medicare and Medicaid). In this process, the Investigator determines the need for Prepay and Postpay review. HI deploys a multidisciplinary team which includes investigators, nurses and data analysts to review requests for prepay and postpay analysis. This helps to define resources needed for the investigation, the parameters of the review, and necessity of conducting review.

During this preliminary process, other administrative actions are considered for action such as revocation of the provider and payment suspension of future claims submitted by the provider. This helps define for the Investigator milestones to watch for during the process and is further defined through investigative file review with their Lead Investigator. If an investigation determines a postpay review is warranted, the Data team is engaged to define the Medicare claims universe/population and a Statistically Valid Random Sample is drawn. Provider records, principally the patients' medical records are requested at this point. The Medical Review Team then reviews the obtained provider records and analyzes the details of the medical services documented against Medicare National and Local Coverage Determinations, Federal Register requirements for meeting the Medicare standards for claiming medical services, Medicare Program Eligibility Documents, and specific state Medicaid Policies in the event that the patients/beneficiaries are dually eligible for Medicare and Medicaid services. In the case of dual eligible involved claims, state Medicaid records are obtained and considered in the investigation.

During the entire investigation, Health Integrity is looking to implement any available administrative action that can be taken to effectuate a correction or elimination of the identified fraudulent or abusive claims submission or medical service scheme. For instance, if the provider is not located at the physical office location where they say they practice medicine or deliver the medical service and no change of location is noted at the MAC, Health Integrity will implement

an administrative revocation action to remove the provider from the Medicare program and suspended payment for any pending claims. A revocation implements a maximum 3-year "time out" from billing Medicare whereas the suspension holds all payments until a medical review can be performed to determine if an overpayment condition exists if the claims were paid.

If during an investigation, it was determined there is a credible allegation of fraud, Health Integrity will request a suspension of payment (through CMS) to determine the actual overpayment. This process includes a medical review of any claims that are suspended in payment. The ending result is an actual amount of "proper" payments left in escrow that can be applied to any inappropriate payments identified in the postpay review of records. During a typical investigation, where postpay determines or interviews determine credible allegations of fraud, Health Integrity will draft a referral to the OIG for further law enforcement processing. In the instance where OIG is unable to accept the referral, a copy is sent to the FBI and if the Medicaid program is involved (full dual eligible beneficiaries) the State Medicaid agency and Medicaid Fraud Control (MFCU) are sent a copy, as well. If the referral is accepted by OIG, Health Integrity assists Law Enforcement with their investigation through the established Request For Information (RFI) process where the OIG outlines the assistance they need. In the event the referral is not accepted by any agency, HI will request from the provider any overpayments noted and education materials will be given the provider, if no further administrative action could occur.

Examples of this process is our work on the Riverside General Hospital Investigation. A complaint on this provider was received by our Contract Task Order 2 Medi-Medi Department with an allegation that services were not rendered as claimed. Through proactive analysis, it was determined that the facility was supplying an abnormally high number of partial hospitalization

services and acting as a community mental health center. Our investigators interviewed beneficiaries and determined that patients were not receiving services as claimed by Riverside. The facility was placed on suspension and 100% prepay review which in turn resulted in a significant overpayment and savings for the Medicare Trust Fund. The provider was referred to law enforcement which resulted in 5 people indicted and convicted (combined 85 years in prison and over $77 million in restitution). Health Integrity provided expert and fact testimony during the trial. In addition, the provider was revoked from participation in the Medicare program.

Another example is the Doctor Jacques Roy case, originally identified through proactive data analysis. This case involved over 77 home health agencies in which Roy allegedly referred patients for unnecessary home health services. The case escalated to an identified $375 million in Medicare payment fraud. Health Integrity assisted law enforcement by placing 77 home health agencies on payment suspension, conducted in excess of seven hundred beneficiary interviews that resulted in the identification of additional overpayments and revocations. This case resulted in a conviction of Roy (and three other defendants) in April 2016 in which, Roy was convicted of conspiracy of health care fraud. Health Integrity provided expert and fact testimony during the trial.

Another example includes collaboration with CMS and the Texas State Medicaid Health and Human Services-OIG to conduct onsite investigations. In the past year, Health Integrity and CMS has conducted three separate projects involving home health agencies and referring providers with no prior relationships (beneficiaries referred by provider but no prior relationship with said referred provider). To date, these efforts have resulted in multiple payment suspensions, revocations, and referrals to law enforcement. Most recently, one of the referring physicians was indicted and arrested in McAllen, Texas.

Health Integrity's work as a ZPIC also includes identifying and reporting program vulnerabilities to CMS for their consideration in making program policy or procedure changes. For instance:

Health Integrity identified a gap in Medicare policy in how many different providers could provide diabetic test strips to one patient. In Oklahoma, we found up to 15 DME providers were providing diabetic tests strips to one patient. Through beneficiary interviews, it was determined that the patient in fact had several different types of diabetic monitors that they were using that were provided "free" by these agencies. The current policy does not support the number of monitors a patient can have; therefore, leaving a vulnerability for providers to take advantage of the system.

The work of the ZPIC's is an important function in the overall CMS effort to combat fraud, waste and abuse in the Medicare program. We are proud of the contributions we have made in this process. This concludes my prepared statement and I welcome your questions.