Feds Recovered $2.5 Billion From Medicare Fraud

BY ALICIA AULT

The federal government recovered $2.5 billion in fraudulent Medicare payments in 2009, government officials said at a briefing.

The Affordable Care Act—one of the health reform laws—gives government agencies new enforcement powers and new funding to go after fraud and abuse, and physicians may find themselves under increased scrutiny as a result.

Daniel Levinson, the Health and Human Services Department Inspector General, said that the Affordable Care Act will require providers and suppliers to adopt compliance programs that meet core criteria. He added that his office will provide training to health care providers once those criteria are issued.

According to HHS Secretary Kathleen Sebelius, the Affordable Care Act provides $600 million over the next 10 years to combat fraud and abuse. The law will make it more difficult to become enrolled as a Medicare or Medicaid provider, as potential providers will be categorized as presenting a high, medium, or low risk of fraud at the time of enrollment. More face-to-face checks will be used to verify a provider's legitimacy, she said. The law increases penalties for fraud, and puts more emphasis on real-time detection of fraud and abuse as opposed to the "pay and chase" model that's used now.

HHS and the Justice Department will look closely at adopting strategies used by credit card companies to immediately flag aberrant charges, said Ms. Sebelius. Preventing waste, fraud, and abuse is especially important as the cost of health care continues to rise, she added. "For years, we've tolerated health care fraud," she said. "We've accepted that with any big enterprise there was going to be some waste and abuse, but those days are coming to an end."

'For years, we've ... accepted that with any big enterprise there was going to be some waste and abuse.' With the joint efforts of HHS and the Department of Justice, those days are coming to an end.

In 2009, the federal government received about $1.6 billion in settlements and judgments from hospitals, physicians, other health care providers, drug and device makers, and non-health providers that were found to have illegally billed federal health care programs. With penalties and settlements, $2.5 billion was returned to the Medicare Trust Fund and $441 million to Medicaid, according to the Health Care Fraud and Abuse Control Program Report.

In all, 583 individuals were convicted of health care fraud in 2009 by U.S. attorneys' offices and federal prosecutors. On the civil side, the Justice Department opened 886 new investigations and had 1,155 civil fraud matters pending.

Physicians were among those convicted or fined for fraud and abuse schemes. A California physician paid $2.2 million to settle allegations that in 2002-2006, he allowed his universal provider identification number to be used to bill Medicare for respiratory therapy. A Kansas cardiologist paid $1.3 million to settle allegations that his group submitted claims for services not provided.

Ms. Sebelius and Attorney General Eric Holder highlighted efforts by the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Medicare Fraud Strike Force, which was begun in 2007 to address durable medical equipment fraud and abuse in south Florida. The strike force has since been expanded to focus on potential hot spots of potential fraud, identified by claims patterns. In 2009, Los Angeles, Detroit, and Houston were added; now the strike force also operates in Brooklyn, N.Y., Baton Rouge, La., and Tampa, Fla.

Ms. Sebelius said that new types of scams are emerging, as criminals attempt to take advantage of seniors who may not understand the health reform laws. Scam artists have gone door-to-door in some states selling bogus "ObamaCare" policies, or asking Medicare beneficiaries for identifying information to issue "new Medicare cards," she said.

Other scams are tied to the issuance of rebate checks to Medicare beneficiaries whose Medicare Part D drug expenditures push them into the doughnut hole, Ms. Sebelius said. The HHS is working with advocacy organizations to educate laypersons who can train their peers how to recognize illegal and inappropriate come-ons, she added. ■

UnitedHealth Settlement: Physicians Must File by October

BY MARY ELLEN SCHNEIDER

Check your mailbox. If you provided covered out-of-network services to patients insured by UnitedHealth Group between March 1994 and November 2009, you may be eligible to receive payments as part of a $350 million settlement reached last year.

The American Medical Association estimates that thousands of physicians will be eligible to be paid under the settlement. Notices with instructions for filing claims are being mailed this month.

The $350 million settlement comes after a nearly decade-long legal battle between UnitedHealth Group and several plaintiffs, including the AMA, the Medical Society of the State of New York, and the Missouri State Medical Association. The groups alleged that UnitedHealth Group conspired to systematically underpay physicians for out-of-network medical services by using an industry database of charges to justify lower reimbursements.

Last year, UnitedHealth Group reached a settlement with New York State Attorney General Andrew Cuomo to discontinue use of the database and the company committed $50 million to fund the development of a new, independent database that will determine the rates paid for out-of-network care.

In a separate settlement, the company agreed to pay $350 million to reimburse health plan members and out-of-network providers who were underpaid as a result of the flawed database calculations. Physicians and patients have until July 27, 2010, to opt out of the settlement. Claims for payments from the settlement fund are due by Oct. 5, 2010.

To be eligible to receive part of the settlement, physicians must have provided covered out-of-network services or supplies between March 15, 1994, and Nov. 18, 2009, to patients covered by a health plan that was either administered or insured by UnitedHealthcare, Oxford Health Plans, Metropolitan Life Insurance Companies, American Airlines, or one of their affiliates. In order to be eligible, physicians must have been given an assignment by the patient to bill the health plan.

Physicians billed via an assignment if they received a payment directly from the health plan, if they completed box 13 on the HCFA/CMS 1500 form, or if they marked yes in the benefits assignment indicator on an electronic health care claim, according to the AMA.

Physicians who are owed money by a patient for a covered out-of-network service or supply cannot file a claim through the settlement; however, they can contact the Settlement Claims Administrator to find out if any of their patients have submitted claims to the settlement fund. ■

For more information, contact the Berdon Claims Administration LLC at 800-443-1073 or unitedhealthcare@berdonclaimsllc.com.

Ranks of Americans Lacking Insurance Grew in 2009

BY ALICIA AULT

The number of uninsured Americans rose last year, with 21% of all adults aged 18-64 years reporting that they were uninsured at the time that they were interviewed for the National Health Interview Survey, federal officials reported.

That's up from 19.7% the previous year and reflects a trend over the past decade of an increasing lack of health insurance, at least among adults, according to a survey by the National Center for Health Statistics, a part of the Centers for Disease Control and Prevention. Rates of coverage for children, on the other hand, have mostly improved.

Since 1999, increasing proportions of people have reported that they were uninsured at the time of the annual survey, for part of the year prior to their interviews, and for a year or more, said the NCHS in its report, which was released early and will be published in CDC's Morbidity and Mortality Weekly Report.

Overall, 46.3 million people—or 15.4% of the population—were uninsured at the time they were interviewed in 2009. The survey found that even greater numbers of people reported that they were uninsured for at least part of the year before the interview—some 58.5 million—but that a slightly smaller number, 32.8 million, had been uninsured for more than a year at the time they were queried.

A greater proportion of children than adults were covered by public health plans, which could explain the children's higher rate of coverage, according to the survey. In 2009, 37.7% of children younger than 18 years were covered by a public plan, up from 34.2% the previous year. Rates of public coverage for low-income children increased. Federal officials in both the Obama and Bush administrations have emphasized enrolling more eligible children in the public Children's Health Insurance Plan, which is administered by states.

Conversely, only 14.4% of adults aged 18- 64 years had public coverage. And private coverage for adults declined from 68% in 2008 to 66% in 2009, according to the survey. There was no significant change in private coverage for children of any income level.

Hispanics were least likely to have insurance, with one-third reporting no insurance at the time of the interview or for part of the past year. A quarter had had no coverage for more than a year. Not surprisingly, states with larger Hispanic populations had greater proportions of uninsured. One-quarter of Texas and Florida residents younger than 65 years were uninsured at the time of the interview. One-fifth did not have coverage in California and Georgia. In Florida, 13% of children lacked coverage when interviewed, and in Texas, that number was almost 17%.

Nine states had lower rates of uninsured than the national average of 17.5%. ■

More information on the NIH survey is available at www.cdc.gov/nchs.