Teaching Physician
Compliance
ALERT
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Turning up the Heat

The federal government turned up the heat on fraud prevention efforts and recovered more than $4 billion in taxpayer dollars in Fiscal Year 2010, the largest sum ever recovered in a single year, from people who attempted to defraud the healthcare programs.

Federal officials credited the Health care fraud prevention and Enforcement Action Team (H.E.A.T.) with the success. HEAT, a joint partnership with the Department of Health and Human Services (HHS) and the Department of Justice, was created in 2009 to gather resources across government to help prevent waste, fraud and abuse in the Medicare and Medicaid programs.

FY 2010 accomplishments included:

- 140 indictments filed against 284 defendants who fraudulently billed the Medicare program more than $590 million;
- 217 guilty pleas and 19 jury trials litigated, winning guilty verdicts against 23 defendants; and
- Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration.

Federal prosecutors opened 1,116 criminal health care fraud investigations, and filed criminal charges in 488 cases involving 931 defendants. A total of 726 defendants were convicted during the year.

In addition, 2010 was a record year for recoveries obtained in civil health care matters brought under the False Claims Act—more than $2.5 billion, which is the largest in the history of the Department of Justice.

While these results are encouraging, not everyone was impressed. Senator Chuck Grassley requested that more scrutiny be given to how tax dollars aimed at healthcare fraud are allocated and spent. He expressed concern over the stagnating number of criminal prosecutions for healthcare fraud, despite increased federal spending to fight fraud.

"Statistically speaking, the data shows that despite increased cases and defendants, fewer bad guys are going to jail for ripping off Medicare and Medicaid. I want to know why the Justice Department is having a tougher time putting people behind bars when we're giving them millions more to do the job," Grassley said.

Affordable Care Act Expands Fraud Investigators Arsenal

Thanks to the new law, the growing list of tools and resources that fraud investigators have to help fight fraud now include:

- A rigorous screening process for provider and supplier types, which pose a higher risk of fraud, enrolling in Medicare, Medicaid and Children's Health Insurance Program (CHIP).
- A new enrollment process for Medicaid and CHIP providers. Providers that have been kicked out of Medicare or another State's Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- Temporarily stopping enrollment of new providers and suppliers. Using advanced predictive modeling software, such as that used to detect credit card fraud, Medicare and state agencies will look for trends in health care fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporary suspension of payments to providers and suppliers in cases of suspected fraud. If there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

Navigating Your Way Through the Fraud and Abuse Laws

The Office of Inspector General (OIG) for the U.S. Department of Health & Human Services has released educational materials to assist teaching physicians about the five main Federal fraud and abuse laws designed to protect the Medicare and Medicaid programs. These materials include the following tools and can be found at: http://oig.hhs.gov/fraud/PhysicianEducation/

- A booklet for physician self-study titled, "A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse",
- A companion Power Point Presentation,
- Speaker note set which will assist with the Power Point Presentation
- Video presentation

OIG's Top 10 Most Wanted

Laws can be evaded and punishment escaped unless of course you're listed on OIG's new "Wall of Shame"!

The OIG published it's first ever list of individuals who have allegedly cost taxpayers more than $124 million in fraud. OIG is seeking more than 170 fugitives on charges related to health care fraud and abuse and is looking for the public's help in tracking down these fugitives.

Besides photos and profiles of the fugitives, the OIG website also includes an online fugitive tip form and the OIG hotline number (1-888-476-4453) to report fugitive-related information 24 hours a day, 365 days a year. Since the list was released on February 3, 2011, two fugitives have been captured and two new ones added. To see the current list of fugitives go to: http://oig.hhs.gov/fugitives/

In the News

Former Haven Health Care Bookkeeper Pleads Guilty to Fraud and Tax Charges

Serena Sylvia, a regional accounts receivable manager for Haven Health Care Management, LLC, pled guilty to one count of health care fraud and one count of filing a false income tax return. From 2005 to 2008, she embezzled funds from nursing home resident trust fund accounts. The nursing homes involved include Haven Health Center of Jewett City, Haven Health Center of Norwich, Haven Health Center of Waterford, and Haven Health Center of Soundview in West Haven. She admitted taking more than $53,000 from the trust fund accounts, and not paying income tax on the money she stole. She faces a maximum imprisonment term of 10 years and a fine of up to $250,000 on the health care fraud count, and a maximum term of imprisonment of three years and a fine of up to $100,000 on the false tax return count.

This case stems from a larger investigation into fraud at Haven Healthcare, a chain of nursing homes formerly headquartered in Middletown, Connecticut. That investigation has resulted in convictions of Raymond Termini, the former CEO of Haven Healthcare; Fred Dalicandro, the former director of Cash management of Haven Healthcare, and Kimberly Boccacio, the former administrator of Haven Health Center of Jewett City.

Health Net to Pay Vermont $55,000 Fine to Settle AG Health Data Breach HIPAA Suit

Health Net has agreed to pay $55,000 to Vermont to settle charges stemming from the health insurance company's loss in May 2009 of a portable hard drive containing protected health information for an estimated 1.5 million members. Of that, 525 members were from the state of Vermont. Affected states were not notified of the lost disk until November 2009. Health Net was charged with violating the state's Security Breach Notice Act - which requires breach notice within a reasonable length of time—by failing to notify Vermont residents of the security breach until six months after the incident. The complaint also alleged that the insurer had failed to comply with the HIPAA Privacy Rule and Security Rule. Health Net is required to submit to an audit and file reports with the state on the firm's information security programs for the next two years.

Nurse of the Year…

She's not! Betty A. Lichtenstein (also known as Betty A. Trudel and Betty Ann St. John), a Danbury woman who worked as a registered nurse, pled guilty to one count of practicing nursing without a license, one count of criminal impersonation, and one count of forgery in the second degree. She was named "Nurse of the Year" in a 2008 award dinner hosted by the Connecticut Nursing Association. The problem is this association doesn't exist and the dinner was staged and paid by Ms. Lichtenstein herself. The impetus for the unraveling of this deceit came in the form of a patient complaint filed with the State of Connecticut Department of Health in March of 2009 that a nurse in Dr. Gerald B. Weiss' office acted unprofessionally. Investigations revealed that she was never licensed to practice nursing yet was administering medications, writing prescriptions and giving medical advice to patients. She also forged several narcotic prescriptions for herself. She was sentenced to five years imprisonment, suspended after nine months, and three years probation.

DPH Warns of Fraudulent Phone Calls

The Connecticut Department of Public Health (DPH) is warning licensed health care practitioners of fraudulent phone calls from a person posing as a DPH employee requesting personal information.

Inquiries received by the DPH indicated the person posing as a DPH employee informed the licensee that there was no longer a license renewal grace period. The person then requested the licensees' email addresses. The department has not been contacting licensees regarding a change in the license renewal process. There has been no change in the grace period. Health care practitioners may still renew their licenses up to 90 days after the license's expiration date.

Following are some tips for determining whether or not you receive a legitimate call from the Department of Public Health: For those with caller identification, all DPH calls will originate from telephone number (860) 509-8000.

- If you are suspicious of a call, take down the person's name and direct phone number. All phone numbers for DPH licensing staff begin with (860) 509-xxxx. Check to see if your license is current at https://www.elicense.ct.gov/.
- Report any suspicious calls to the DPH at (860) 509-7590 or send an email to oplc.dph@ct.gov .

http://www.ct.gov/dph/cwp/view asp?Q=473746&A=3987

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