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The cure for bogus bills: Federal crackdown on Medicare fraud in metro Detroit hits it big

By Chad Halcom

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The **U.S. Department of Justice** could dub 2013 the year its fight against Medicare billing fraud in Southeast Michigan yielded the first real payoff.

Last year, the **Detroit Medicare Fraud Strike Force**, deployed here from Washington, and a locally organized Health Care Fraud Unit of prosecutors together brought charges in fraud schemes billing more than $380 million to the federal program. That's more than double the bad billing amount charged in any preceding year.

It's been a slow build since the strike force came to Detroit in 2009 as part of the national **Health Care Fraud Prevention and Enforcement Action Team**, referred to as HEAT, to ferret out what data analysis suggested was hundreds of millions worth of fraud here.

The effort is gaining traction, according to both investigators and a *Crain's* analysis of local casework and Justice data.

In 2013, federal prosecutors obtained 18 local indictments against 46 defendants in fraud schemes totaling $380.2 million — fueled by $225 million in unnecessary medical treatment attributed to oncologist Farid Fata — but even without that, higher than the previous record of $143.3 million in billings charged in 2011.

Medicare indictments

Below are the Medicare indictments since the U.S. Department of Justice's Detroit Medicare Fraud Strike Force began assisting the local U.S. attorney's office with Medicare fraud investigations. The first full year of the task force was 2009. Indictments for that year cover billings over several previous years. */

Year	Billings	Cases	Defendants
2009	$75.6 million	11	88
2010	$24.5 million	3	25
2011	$143.3 million	11	147
2012	$121.5 million	11	35
2013	$380.2 million	18	46

But more significantly, that figure approaches for the first time the billing volume that experts believe is likely fraudulent within the $5 billion-plus in annual Medicare expenditures in Southeast Michigan. Since the first indictments from the increased enforcement presence came down in June 2009, nearly 170 people have pleaded guilty and nearly three dozen were convicted by juries. Another 110 await a finding by a jury or judge this year, including three who are on trial this week before U.S. District Judge Arthur Tarnow.

Investigators said the success is due to a mix of cutting-edge surveillance and witness interviews that establish crossover points between one bad billing scheme and another.

Over time, Justice has begun to catch criminals before they close shop and change markets as in years past, and the trickle of closed cases has become a verifiable stream.

Feeling the HEAT

Local prosecutions from the national HEAT program, a collaboration between Justice and the **U.S. Department of Health and Human Services**, and by the local Health Care Fraud Unit, formed by U.S. Attorney Barbara McQuade in Detroit in 2010, have together roped in 341 defendants in $745 million of alleged fraudulent Medicare billing schemes to date.

"Based on Medicare spending data, we see per-beneficiary spending is going down in this market. One possible conclusion from that is we are indeed making headway," McQuade said.

"That's consistent with what we see, but a lot of the law enforcement community will tell you about the balloon effect, where squeezing one area (of fraud) makes another expand."

The decline in per-beneficiary spending is tentative — the most recent year available is 2010, but it shows that reimbursements from Medicare fell anywhere from $50 to $400 per enrollee in five Southeast Michigan hospital referral regions from 2009, which was the first year of strike force prosecution. The regions saw nothing but increases the preceding five years.

Even so, the $10,944 average expenditure per Medicare enrollee across the region is more than the average payout in 90 percent of the 306 regions tracked nationwide.

The per-beneficiary data is compiled by the Dartmouth Atlas of Health Care, a program of the **Dartmouth Institute for Health Policy and Clinical Practice**.

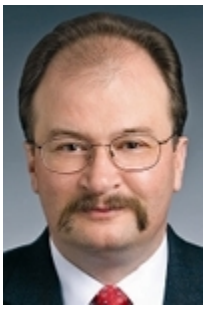
Since January 2011, McQuade said, the amount billed to Medicare for psychotherapy locally has gone down by 70 percent, and home health care has seen reduced billings, although billings are still generally high.

"We do have a recently intercepted conversation on wiretap, where two individuals were recorded saying they need to be more careful now because they're really cracking down in this area. That's encouraging," McQuade said.

"Does that mean criminals stop, or do they go elsewhere? That's hard to know. But when you do bring down some of the actors, you do seem to bring down at least some of the fraud occurring along with them."

Nationwide, more than 1,500 people have been charged since March 2007 in connection with more than $5.1 billion in Medicare billings, by the strike force in nine cities where software operated by HHS found disproportionate Medicare billing volumes believed to be due to fraud.

Search for cases by name, value of claim and industry category.



"The majority of the HEAT task force prosecutions have dealt with the worst of the worst, and blatant, egregious violations — and more power to them, because that's my tax dollars, too," said Mark Kopson, chairman of the health care industry group at Bloomfield Hills-based **Plunkett Cooney PC**.

"But unfortunately, while there will always be an element out there willing to exploit any weakness imaginable, and it's always changing tactics, it really only represents one end of the spectrum of behaviors in the industry."

Kopson and other attorneys said increased Medicare fraud enforcement has triggered compliance work among health care providers to help develop new policies and controls or increased internal audits.

For example, **Crittenton Hospital Medical Center** in Rochester Hills stopped charging patients fees for releasing their medical records after the August indictment of Fata, who is accused of billing for hundreds of chemotherapy sessions that were medically unnecessary. (*See story.*)

"Ideally, you do want the payer, which is Medicare here, to be careful about the money it spends. And you'd want them to be sensitive to the treatment cost it pays for," said Nicholas Bagley, an assistant professor of health law and policy at the **University of Michigan Law School** and a former appellate attorney in Justice's civil division.

"But the program has been hobbled since its inception by the competing desire to make sure that Medicare doesn't meddle in treatment decisions. Still, the fact that it's really easy to find Medicare fraud and deter it suggests that it's also very easy to defraud the system, and perhaps we are only scratching the surface."

A question of traction

The **National Health Care Anti-Fraud Association**, a Washington, D.C.-based organization of public and private health insurers and regulators, estimates 3 percent of total health care spending, or more than $60 billion per year nationwide, is misspent on fraud. That includes Medicare, Medicaid and all private insurance reimbursement.

According to the Dartmouth Atlas, Medicare alone reimbursed a total of $5.39 billion in claims for 496,760 Medicare plan enrollees in Southeast Michigan in 2010, which is the most recent year available.

If the 3 percent spending estimate by the Anti-Fraud Association is correct and can be applied to Medicare alone, that would mean $161.7 million of Medicare reimbursements from Southeast Michigan each year are fraudulent.

Medicare fraud becomes a crime at the moment the provider submits a claim — not when or if it gets reimbursed — but defendants are charged with the amount of the total billings.

A review of indictments by *Crain's* suggests Medicare generally pays out 25 to 40 cents on the dollar it is billed on a fraud scheme before participants are arrested and charged.

So if fraudulent spending is more than $160 million in Southeast Michigan, then local fraudulent billing claims may well exceed $400 million a year.

That's assuming, of course, that Detroit's fraud rate is commensurate with the nation as a whole — the 2009 Strike Force assignment to Detroit is based in part on a finding of outsized billing amounts detected here by HHS Fraud Prevention System software.

Peter Orszag, former **U.S. Office of Management and Budget** director, has said in past reports to Congress that up to 30 percent of Medicare costs could be saved by bringing high-cost hospital regions into line with lower-cost areas of the country, without negatively affecting health outcomes. So fraud may be only one factor behind inflated spending in Michigan.

"The bigger problem here is other forms of claim abuse, such as discretionary calls by providers, that can lead to overtreatment," Bagley said. "In the scope of all spending, fraud is sort of the leading edge of the problem."

'A regional issue'

Andrew Arena, executive director of the **Detroit Crime Commission**, said Southeast Michigan was one of the top three regions in the country for health care fraud while he was special agent in charge at the FBI in Detroit. Single-market fraud often has to significantly exceed national norms to be detected by HHS investigators, he said.

About six years ago, some fraud scheme operators were moving to metro Detroit from Florida, a previous fraud hotbed that was facing pressure from Justice, Arena said.

"Health care fraud enforcement is certainly a regional issue. Some of the schemes and practices migrate, and concentrate in certain local areas," said Leigh McKenna, director of government and public affairs for the Anti-Fraud Association. "South Florida is a perennial area because of the large volume of beneficiaries, but you get upticks in other markets for periods of time."

Prison sentences help, officials said, but they aren't the answer.

"It's not a problem you arrest your way out of. It's going to have to be solved with regulation, but it's a question of what kind of regulations would be effective," Arena said.

"You've (also) got to police and enforce smarter. That's where software solutions and algorithm expertise come in. From an effectiveness standpoint, that's what you've got to invest in — the technical ability to enforce."

The **Centers for Medicare & Medicaid Services** in 2012 launched a Program Integrity Command Center, a digital prevention and crime detection center for CMS to coordinate with law enforcement agencies that uses the Fraud Prevention Systems software's predictive analytics to spot fraud and respond quickly to it, said Tony Salters, public affairs specialist at CMS.

The result is that investigations that used to take days and weeks can now be done in a matter of hours, Salters said.

Kopson agreed that new tracking technology seems to bring the hammer down faster on scams.

"Real-time billing monitoring by the government has been very successful at discovering real-time fraud, and that by the time you catch up on it, the bad guy hasn't already packed up and moved to another state, which used to be more common," he said.

Complex cases

The increased federal presence and Medicare fraud crackdown seem to have benefits in other areas of health fraud, although local investigators said it is hard to measure how much correlation exists.

Blue Cross Blue Shield of Michigan, for example, tracked 132 arrests stemming from allegations of fraud against the insurer totaling $13.5 million, as of late 2013. That's compared with 77 arrests in fraudulent claims totaling $13.1 million in 2012 and about just $8 million in fraud allegations in 2007, before the federal strike force arrived.

Greg Anderson, vice president of corporate and financial investigations at Blue Cross, told *Crain's* that investigations of Medicare and Blue Cross insurance fraud often overlap, and his department has a good relationship with the FBI, including sharing information on overlapping cases.

But sometimes, Anderson said, the government's own complex Medicare fraud cases consume tremendous time and effort, which can mean less time for Justice to follow up on case referrals from his company or others, he said.

Blue Cross' fraud-flagging efforts have included hiring recent veterans of the law enforcement community, offering basic and advanced investigative training, and tracking case outcomes and restitution payments over time, Anderson said.

Blue Cross also said it was difficult to break out its annual arrest and fraudulent billings totals into federal cases versus state law violations, which are less likely to involve Justice officials.

In 2013, the inspector general's office also reported reaching corporate integrity agreements with two Michigan companies to change their practices and disclose more to the federal government — W.A. Foote Memorial Hospital, or **Allegiance Health**, in Jackson; and **Jackson Cardiology Associates PC**, owned by cardiologist Jashu Patel — compared with one such agreement each in 2011 and 2012 and none in 2010.

Those companies were also part of a civil action in Detroit, where McQuade's health care fraud unit intervened as a plaintiff and resolved the matter in July 2013. Patel and Jackson Cardiology agreed to pay $2.2 million in a civil settlement while Allegiance Health agreed to $1.8 million, to settle civil claims that Patel and his cardiologists performed medically inappropriate cardiac procedures, including invasive catheterizations at Allegiance Health.

McQuade said her office gets data episodically that suggests the local fraud picture is improving, but it is too soon to tell if the task force's work in Detroit is nearly done.

"At some point we fully expect a decision to come down that another market needs the task force more than Detroit does, and they will move on. So in the meantime, they have been doing a lot of training and cooperating with our own staff to carry on," she said.

"Because the work (of fighting fraud) is here to stay, whether the national task force is here to be a part of it or they go their own way."

Chad Halcom: (313) 446-6796, chalcom@crain.com. Twitter: @chadhalcom

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